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Meeting Spaces: crafting conversations about suicide in nurse education

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Meeting Spaces: crafting conversations about suicide in nurse education

Annessa Charlotte Rebair

A thesis submitted in partial fulfilment of the requirements
of the University of Northumbria at Newcastle for the
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Meeting Spaces: crafting conversations about suicide in nurse education

Abstract

The care of suicidal people has featured consistently in government policy over the last two decades with continuous reference to educating frontline health care staff to notice and respond to those in need. However, until recently (May 2018), none of the fields of nursing in the UK (apart from mental health nursing) were required to meet competencies in suicide awareness or prevention. There continues to be a gap between what is being suggested from a governmental position to what is happening in preregistration nurse education and practice. It is arguable that all nurses should be able to ask about and respond to suicidal persons, given the tenets of the Nursing and Midwifery Code of Conduct. Given this gap and evidence from literature (mainly concerned with risk and negative attitudes) it was evident that engaging in conversations about suicide was an area of tension in nursing and in need of further understanding.

The aim of the research was to gain understanding of student nurses' and suicidal persons' experience of engaging in conversations about suicide. The research question was: *what is needed to support and engage in conversations about suicide?* As the aim was to understand social reality grounded in the subjective experience of meaning, an interpretive methodology of grounded theory was used. This was underpinned by the theoretical perspective of symbolic interactionism.

Data was collected via semi structured interviews, focus groups and field notes from those who had been suicidal (n=9) and student nurses (n=16). Of those who had been suicidal, seven participants were female and two were male with ages ranging from twenties to sixties. Sixteen nursing students were interviewed across three years of an undergraduate nursing degree programme; of these, fourteen were female and two male.

The importance of space emerged as a theme throughout the data analysis. The core category was *Meeting Spaces*. For those who were suicidal the three categories were: 1. *Lost in uncharted space*; 2. *Cycling in distorted space*; 3. *Emerging in illuminating space*. There were distinct areas of overlap with nursing students. These were categorised as; 1. *Limiting space*; 2. *Distorted space* and 3. *Illuminating space*. Meaningful conversations about suicide were co-created in illuminating space in what was considered a *human pivotal encounter*. A specific kind of space is required to support meaningful conversations about suicide, as the experience of the encounter incorporates more than just words. Reflecting on Martin Buber's teachings on spirituality, the formation of a meeting space requires fully embracing the other with awareness and intention, energetically extending boundaries of physical self into the surrounding space. It is here, in the space in between, the borderlands, that an authentic experience can be co-created. The grounded theory was constructed into a theoretical framework: *The Meeting Space Framework; crafting conversations about suicide in nurse education*. This offers a novel approach to preparing students to be genuine and human with themselves and with suicidal persons.

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To my cosmic soul friends Tez and Amanda, always there in an array of colour and light.

For Mam and Dad

Who despite everything remain hopeful and relentlessly supportive and loving.

Declaration

I declare that the work contained in this thesis has not been submitted for any other award and that the work is my own. I also confirm that this work fully acknowledges opinions, ideas and contributions from the work of others.

Any ethical clearance for the research presented in this thesis has been approved. Approval has been sought and granted by the Faculty Ethics Committee on 25th January 2016.

I declare that the word count for this thesis is **61,342**

Signed:

Annessa Charlotte Rebar

Date: 27th November 2019

The Structure of the Thesis

Feedback from assessors at an annual review advised me to include ‘more of me’. Therefore in keeping with the spirit of a socially-constructed piece of research, I have begun with a personal account exposing subjectivity. Appropriate metaphors are used throughout the thesis, these are in keeping with those used by participants and stem from the emergent categories of spaces. The thesis is presented in three sections, each extracted from the findings and punctuated with short excerpts from my travel journal (I travelled the world for a year from 2003- 2004). The excerpts offer elements of reflexivity and connectivity across historical and cultural interfaces. They serve to weave the concept of travelling ‘through’ as well as an attempt to openly demonstrate (much more simply than is woven into the complex fabric of life) the multiple viewpoints and voices that co-create stories and shape an ever-evolving understanding of our experiences.

Part I – Arriving to Suicide

Chapter One - Background - Byker bridges. Here I introduce the story of why and share my subjective position.

Chapter Two - Introduction to the thesis; a brief overview of the current climate and why suicide awareness and prevention is important for nursing.

Chapter Three - Reviewing the literature; grounded theory posits an initial review of the literature for orientation and a return to the literature with the emerging categories and themes. This process is explained here along with arriving at the research question, aims and objectives.

Chapter Four - A review of relevant and background literature and research related to suicide; suicide in space, place and time. This includes medical, social and political perspectives. The initial literature search findings and further searches are presented together.

Part II – Cycling

Chapter Five - Developing the conceptual framework; details of the conceptual and theoretical framework are discussed. Constructivism, symbolic interactionism, interpretivism and details of grounded theory methodology are presented.

Chapter Six - Research considerations and methods; the process of ethical approval, sampling and grounded theory methods are explained.

Part III – Emerging

Chapter Seven - Findings and discussion; the findings and relevant literature and research form a discussion in this chapter demonstrating the relevance of the data findings. Categories and a core category are presented.

Chapter Eight - Meeting Spaces; theoretical abstraction led to the core category of *meeting spaces*. This is discussed in the context of spirituality and concepts about the spaces we occupy.

Chapter Nine - Proposing a framework for conversations about suicide in nurse education; from the grounded theory, a proposed framework is constructed incorporating Buber's teaching on spirituality (Kramer, 2012). This is the original contribution to knowledge from the research undertaken.

Chapter Ten – Conclusion: Reflecting Back-Moving Forward; reflections on the research process including research credibility and limitations are included in this chapter. There is discussion about translating the *Meeting Space Framework* to education and practice. Policy and research and related challenges are discussed and finishes with concluding thoughts.

How wild the wind blows

The acorn carries an oak tree
Sleeping but for a little while
Winter lies in the arms of spring
As a mother carries her child
And never knows
How wild the wind blows
A thought carries a universe
A seed carries a field of grain
Love lies in the arms of change
As a joy carries pain
And no one knows
How wild the wind blows

The Unthanks – Songs and Poems of Molly Drake

Part 1

Arriving to Suicide – Lost in Uncharted Space

24th June 2003, somewhere over the Atlantic Ocean

This is it. I'm on a plane to Rio. It's the beginning of an around the world trip. I have no idea how it will be, I know what I hope for but at the minute I am full of sadness and concerned with the fragility of the human spirit....

'...and I didn't realise I had these issues at all it suddenly just hit me like a giant tsunami of emotion and I couldn't deal with it I didn't understand it I, just knew I wanted to die'

(Pauline, 106 -107)

Chapter One

Background – Byker Bridges

The following chapter presents the basis for this thesis. It is hoped that it is of enough transparency to allow the reader to see my subjective position and ideological commitments as influenced by my social location, ethnicity, social class, gender, institutional position and life experience. These are noted by Ravitch and Riggan (2012) to be significant considerations in evaluating the qualitative approaches of the researcher. However, according to Glesne and Peshkin subjectivity is ‘something to capitalise on rather than exorcise’ (1992, p.104). They argue that subjectivity is the basis of the story that one can tell. This of course still requires a critical eye over one’s subjective position and focal lens. Heron and Reason (1997) describe this as critical subjectivity, a quality of awareness to primary experiences that is raised to consciousness and acceptance of being in the world. Sharing of subjective experiential knowledge is one contributing part to constructing the conceptual framework (Maxwell, 2005). This, and the wider theoretical and epistemological assumptions compatible with my position, are discussed in more depth in chapter five.

Suicide was a feeling I learned about at a young age. Growing up in the working-class area of Byker in East Newcastle meant that geographically there were regular crossings over several bridges interconnecting each side of the city. Byker Bridge, Armstrong Bridge and the Tyne Bridge were places we regularly traversed. These bridges were also known to be places frequented by those in distress finding themselves on the edge of life. It was not unusual to hear from the low hush of neighbours that someone had taken their own life from one of these bridges. I do recall feelings of sadness from childhood memories when learning about this aspect of life. Details escape me, though the memory of living in a ground-floor flat tells me that it must have been around 1979/80, and I was around six years old. I recall remnants of a conversation with mam and the confusion of trying to understand how someone arrives at the ledge of a bridge and why love wasn’t enough to intervene. Like most memories they are distorted with time. Recollections are of a conversation in the living room. I followed my mam there after overhearing the shock of neighbours in the front street as they shared the latest tragedy of Byker Bridge. It went something like this:

Me; mam why did the man jump from the bridge?

Mam; I think you are a bit young to hear about things like that, let’s not talk about it just now

Me; but everyone is talking about it outside, is he ok?

Mam (long hesitation)

Me; (getting upset) why did he do that?

Mam; sometimes I think people are very sad and they don’t want to be here

Me; where was his mam and dad?

Mam; I don’t know, maybe they didn’t know, maybe they aren’t here

Me; what about nana and granda?

Mam; he might not have a nana and granda

Me; but what about friends?

Mam; there might not be any friends, he might have been alone

Me; you mean there was no one there? But how? Why?

Mam; I don't know pet, I just don't know...

Unable to correlate thoughts and feelings with the explanations from my mam, I concluded that 'something' must take the person there and I feared getting too close to the edge of the bridge or to the waterside just in case 'something' took me there unknowingly. Travelling to the city centre via bus over Byker Bridge, exploring the markets at the quayside under the Tyne Bridge and wandering over Armstrong Bridge to enjoy Jesmond Dene hold precious childhood memories, although shared with 'something' that hovered quietly on the periphery; a shadow in my mind's eye.

Somewhere between 1992 and 1996 at university in Scotland, I was reintroduced to the subject of suicide in the context of nurse education. Implicit in training, and considered part of assessment across the general curriculum, the subject was discussed as something that could be potentially experienced across all situations in nursing. I recall orthopaedics; we learned to consider the impact and potential of a sudden change of circumstances in young men after a motorcycle accident for example. I was beginning to understand the many different reasons why someone may arrive at suicide. It was implicit in the then United Kingdom Central Council (UKCC) Code of Conduct that the safety of others was our concern and it was explicitly stated from tutors that we were in a position to illicit concerns and act with care and consideration. It was not questionable, we should ask about suicidal thoughts, it was our duty to do so, and we were in a privileged position to listen. I remember the sense of trepidation as we talked about how it might feel to inhabit such a place; fused with the realisation that as a nurse I was somehow responsible for the safety of suicidal persons. A short spell volunteering with the Samaritans ensued, a move to gain experience and knowledge about how to talk with suicidal people. I recall telephone conversations with people and the bewilderment of knowing that I could not intervene unless they consented. This stood against everything I was taught at university and what I believed. I was a child again concerned with the bridges in Byker, the notion of aloneness and the absence of another human being with the person in need and, unlike in clinical practice, I could not physically reach out and touch the person.

Fastforward to September 2001. I was a community psychiatric nurse back home in the North East, noticing changes in the season, the air being slightly cooler, the hub of activity returning to the roads after the summer break. On this day, I recall a sensation of panic on my way to work and an absolute desire to go to back to my parents' home. Racking my brains as to why this was the case, I reworked conversations of taking my mam to work as my dad and brother were out earlier than usual. I had forgotten. My mother would be late and I would be even later if I turned the car around to get her and

take her to work. I wrestled with the appointments I had in my diary. The anxiety and panic seemed illogical and incomparable to the situation. The panic soon faded to calm as I remembered my brother Tony was not at work. He was taking her. The day continued with no further thoughts of this. I returned to the office in the afternoon where I received a call from the police asking me to attend Byker police station straight away. I was told that my mother was in distress, she had found a student dead at work.

Travelling towards the Tyne tunnel, once more I was overcome with sheer panic, it was difficult to breathe, or to think. I needed to stop. I saw a police car ahead but could not formulate an action to gain their attention. The time of day indicated that my mother had finished work and had returned home. I knew then that she had not found a student, she had returned home to find my brother dead. I knew then that he had taken his life. That ‘something’ of my youth had caught up, shadowing my brother without us really seeing.

Twelve years on, I took up a post as a senior lecturer at a university in the South West of England. In the years preceding this, I had developed an extra sensitivity to people and continued to be privileged to hear stories whilst bearing witness to human pain. I became attuned in being with and taking part in painful conversations. Managing busy acute wards, working with staff and bearing witness to difficult conversations, near misses and serious incidents regarding the safety of patients, including those that were suicidal, implored me to check the nursing curriculum for teaching of the subject of suicide. Surprisingly, the subject of suicide featured little on the mental health curriculum. Reflecting on my own training, I assumed that the subject would appear across other fields of nursing as a shared concern; however, further investigation revealed that this was not the case. Curiosity got the better of me and I tentatively explored the national picture. I discovered that information detailing undergraduate preparation in relation to suicide was scarce, Pre-registration curriculums differed and standards for pre-registration nurse education (Nursing and Midwifery Council [NMC], 2010) did not include suicide prevention as a mandatory competency (except for the fields of mental health nursing). Frustrated with the lack of equity and fuelled by the values nurtured in my early nurse education, I deduced that it was imperative to raise this nationally through the Royal College of Nursing (RCN). This was a moral and ethical problem. Suicide is not limited to mental health services and, therefore, expanding awareness throughout all fields of nursing would increase the potential of noticing people who are thinking about ending their life.

In June 2014, I raised the following motion at RCN Congress in Liverpool; ‘that this meeting of RCN Congress asks Council to influence higher education institutions to include suicide prevention across all fields of pre-registration nurse education.’ The motion was passed after an emotive debate with nurses and nursing students voting 99.6% in favour. Anecdotal information collected by the charity PAPYRUS (prevention of young suicide) from 500 nurses and students at Congress also emphasised limited teaching in this area and the need for this to be imbedded into curricula. The original motion

was to lobby the Nursing and Midwifery Council (formerly the UKCC) as they are responsible for setting standards and competencies for undergraduate nurse education. Higher education institutes are therefore not obliged to teach out-with the standards set for specific fields. The original wording was changed by the RCN as it was considered too politically challenging. This created another personal mission that introduced me to the political heart of suicide.

Experience accumulated during education and since qualifying has demonstrated and reinforced the importance of awareness of suicide. A duty of care and death experienced in professional contexts, coupled with the loss of my brother and the complexities of the resulting impact of those connected to the deceased, deepened with the lived reality of suicide. More specifically, the emotional pain individually experienced and observed in loved ones and the effort and challenge of reconstructing life is an education of living in the wake of suicide. This has involved extensive building work on rocked foundations. Reconstructing a different kind of 'house' from the rubble within reach, each brick representing fragments of a world once understood looking vaguely familiar but no longer fitting in the same place. And, as our lives are constructed together, and our understanding comes from each other, the reconstruction of the house involved patient gathering of old bricks, the making of new ones as loved ones moulded, remoulded and reclaimed areas of themselves. I have learned that the rebuilding from grief is not the task of building a completed house as the house is never complete.

I do wonder how it must feel to be on the brink of ending one's life, to be in a place where suicide is the only answer at a given point in time, how the intensity must be undeniable, and the emotions may be of loneliness, isolation and fear. A fellow human being, a loved one, unable to share and ask for help. For family and friends, colleagues and professionals who did not notice, ask, or who did ask and were met with whispered responses. And for those who did not think that suicide was a possibility close to them, for most. As a young student nurse in my early twenties, peering at the notion of suicide from the safety of my twenty-something year-old 'house,' suicide represented a shadow occupying the periphery, a possibility in daily working life. I look back at my young self peering from the window. I see that the person peering back at me is familiar, though quite different, to who I was then as the shadow morphed into solid matter and now occupies a brick in my reclaimed house.

Chapter Two

Introduction to the Thesis

Since the 1990's, a collective nursing response to suicidal people has featured consistently in government policy with continuous reference to educating frontline health care staff to be suicide-aware and partake in suicide prevention. However, until very recently (May 2018), none of the fields of nursing (except for mental health nursing) were required by the Nursing and Midwifery Council to meet competencies in suicide awareness or prevention in preregistration education (NMC, 2010). In addition, suicide is traditionally housed within the domain of psychiatry, therefore, the impetus to provide training out- with this specialist area is limited. The result is a protracted gap between suggested ideologies from government and the reality of nurse education and practice.

Whilst nursing features as part of the national political strategy to reduce suicides, socially, there are several media responses and campaigns highlighting the dangers of websites related to bullying and subsequent suicide- related deaths. Suicide is a feature of everyday life. Unfortunately, the stigma associated with suicide is too; preventing those in need to seek help and those in a position to help, to ask questions. The last few years have witnessed a thrust in collective energy to raise awareness of suicide. There are regular social media campaigns reaching out to men in a bid to encourage them to talk (men are consistently reported as three times more likely to die by suicide than women (Office of National Statistics [ONS], 2016; 2017a; 2018a). There are campaigns aimed at young people and schools, awareness raising in diverse communities, dedicated suicide awareness days and world mental health days, 'shared' and 'liked' globally at the press of a button. However, living in a digital age that facilitates instant communication and global connectivity does not necessarily mean that people are more united. Young people report to be significantly lonely (ONS, 2018b), with lives expressed via social media carefully crafted to gain connectivity in a world where images speak louder than words (Pitman and Reich, 2016).

Counting lives lost

It is moving to note that since the commencement of this research journey three years ago, approximately 2.4 million people worldwide have died by suicide, (World Health Organisation [WHO], 2014 report over 800, 000 deaths per year). This equates to one person dying every 40 seconds. Suicide is recorded as the second leading cause of death in 15 -29-year olds globally (WHO, 2014) and it is estimated that one person dies every 90 minutes in the UK, with suicide cited as the leading cause of death in middle aged men (ONS, 2017a). Considering available data for the same research period, (ONS, 2016, 2017a, 2018a), a total of 17,359 deaths by suicide were recorded. The ONS (2018a) report a downward trend, though there is no room for complacency as, how suicides are registered in the UK and Republic of Ireland has an impact on the number of reported suicides per annum. Differences include; establishing the cause of death and the time of registering a death. In

England and Wales for example, death is certified by a Coroner, and the ONS is not notified until the death is registered, which could take months or years. Northern Ireland has similar reporting systems, and in Scotland, deaths require registering within eight days to the Procurator Fiscal. Therefore, the release of annual statistics represents the number of deaths actually registered, not necessarily the number of deaths occurring in a given year. This makes comparison of statistics across countries challenging as patterns may be due to differences in recoding. Annual fluctuations in data require data to be analysed across a longer period of time though caution is also required here as since 2011, the ONS, National Records for Scotland (NRS) and Northern Ireland Statistics Research Agency (NISRA) adopted new coding to meet with WHO coding rules. This means that older statistics are not directly comparable and should be treated with caution (Scowcroft, 2017).

The definition of suicide recorded in the International Classification of Diseases, Injuries and Causes of Death 10th revision (ICD-10), WHO, 2011), is intentional self-harm (ICD10: X-60- X84) and events of undetermined intent (ICD10:Y10-34). The UK, National Records of Scotland (NRS) and Northern Ireland Statistics and Research Agency (NISRA) also use this definition, while the Republic of Ireland (ROI) does not (Scowcroft, 2017). The inclusion of undetermined intent was used as a solution to the underreporting of suicides. Due to specific reporting systems, Scotland has proportionally more deaths coded as ‘events of undetermined intent’ (and hence as probable suicides), compared with England, Wales and Northern Ireland (ONS, 2017), and these are included in aggregated statistics for the UK (Scowcroft, 2018).

Suicide was repealed as a criminal act in 1961, yet a coroner must still refer to the criminal standard of proof to establish beyond *reasonable doubt*, as opposed to the civil standard of *balance of probabilities*, that a person has taken their life. Narrative verdicts may also be given detailing circumstances around death instead of cause and intent. Carroll et al. (2012) observe difficulties with this and conclude that coroners should record a short-form verdict with narrative verdicts as they see a failure to do so may lead to inaccurate reporting, impacting upon understanding local trends and variations. The Chief Coroner’s guidance (2015) on short- form and narrative verdicts is clear; suicide should remain a short- form conclusion and with this it must be proven that the deceased, (i) did take their own life and, (ii) intended to do so. Narrative verdicts without short- form conclusions are coded at the Office of National Statistics. If intent is not established verdicts are coded ‘hard to code’ (ONS, 2017a), introducing another variation of determining the actual prevalence of suicide in the UK.

Classifying attempt on life

Many more people attempt suicide than die by suicide. However, suicide attempts are subject to a level of interpretation and classification, rather than being referred to, as it is, an attempt. Attempted suicide or parasuicide is coded under intentional self-harm (WHO, 2011). More recently, a diagnostic category of Suicidal Behaviour Disorder was created (American Psychiatric Association, [APA],

2013). Supporters justify the inclusion saying it (a) meets criteria for diagnostic validity and (b) allows classification out-with other diagnoses such as depression and borderline personality disorder creating clarity for written reports and treatment (Oquendo et al., 2008). Critics retort that suicide is a response to living with no evidence of psychopathology and hence tells us little about the nature of suffering. Thomas Szasz is one such critic and argued that meaning is lost as presentations are grouped according to criteria that no longer fit. He asserts that depression became classified as a mental illness not because it was discovered that it fit the literal meaning of disease or illness; 'having a shared common characteristic with reference to physicochemical state of bodily disorder' (1974, p.40) but because the criterion of what constitutes disease changed from this to; 'the disability and suffering of the person,' a shift from the literal meaning of disease 'to a metaphorical meaning of disease or illness' (ibid). Applying this, the DSM- V classification of suicide as a disorder allows diagnosis and treatment from a set of observable symptoms of a 'metaphorical illness.' In addition, the person is considered to be in remission if the last attempt was over 24 months ago (APA, 2013). Therefore, what is considered a momentary *response to living* for some becomes a life sentence; the person has no ownership, and suicidality becomes a *disease entity* with the threat of reoccurrence.

Why this is important for nursing

Given that two thirds of people who take their own life are not in touch with mental health services (NCISH, 2018), there is significant potential for nurses to unknowingly encounter a suicidal person during their worklife. Equally, research into suicide and occupation (ONS, 2017b) reports that nursing is a high-risk occupation with nurses 23% more likely than the general population to die by suicide. A collective societal repose to suicide, touched upon briefly above, and the expectation that the workforce is fit to respond, poses potential ethical and moral challenges. Suicide is traditionally housed in psychiatry and mental health services, yet with the recent addition to NMC nurse proficiencies nurses are essentially now directed to shift focus from what is traditionally considered a role for psychiatry and psychiatric nursing to encompass the suicidal person as part of their role. Furthermore, how nurses receive the suicidal person raises questions about personal, professional, moral and ethical orientations.

The literature tells us that those who are suicidal would like engagement, time to tell their story, to be met with a genuine human response to their despair, and to be asked about suicide (Cutcliffe et al., 2006; Lees, Procter & Fassett, 2014). One can assume that nurses would be prepared, equipped to listen, ask and respond with compassion to an expression of distress as emotional care extends all fields of nursing. Tenets of the Nursing and Midwifery Code of Practice (NMC, 2015, p4.) remind us:

You put the interests of people using or needing nursing or midwifery services first. You make their care and safety your main concern and make sure that their dignity is preserved, and their needs are recognised, assessed and responded to.

To achieve this, you must:

- 1.1 treat people with kindness, respect and compassion
- 1.2 make sure you deliver the fundamentals of care effectively

This is compounded by a professional and legal duty of care; there is an obligation of the nurse to act in accordance with expected standards. The transaction is far more complex than initially perceived. It involves closeness with a subject that is irrevocably taboo, notwithstanding the supposition that the nurse has the emotional capacity, ability and willingness to engage in conversations about suicide. It is no surprise that the literature informs us that nurses struggle on various levels to have conversations about suicide. This includes mental health nurses who traditionally deliver this aspect of care. A survey conducted with nurse members of the Royal College of Nursing (n= 415) reported lack of preregistration education in suicide awareness and prevention and an identified need for mandatory training pre and post registration, with some nurses reporting never receiving education in this area. Themes such as lack of knowledge, time and non-maleficence were cited as reasons for avoiding conversations about suicide (Rebair and Hullat, 2017).

Nurses may choose to borrow from traditional and evolving theories offered by other disciplines to help form a response to the suicidal person (unresolved psychache, coined by Schneidman (1993)) to explain suicidal behaviour; the feature of hopelessness as an indicator for suicide (Abramson et al., 2000) and explanations such as Joiner's interpersonal theory of suicide (Joiner, 2005) highlighting burdensomeness and thwarted belongingness. More recent prevalent theories include the integrated motivational-volition model and the role of entrapment (O'Connor, 2011; O'Connor and Portsky, 2018). There are similar features across theories yet, there remains a distinct lack of consensus. O'Connor purports that there may be evidence for the role of entrapment in explaining suicide but there are gaps in knowledge (O'Connor and Kirtley, 2018). The desire to understand suicide requires dissection of the components, and the person becomes less than the sum of their parts. As a result, the concept of holism and the subsequent construction of meaning via the nurse-patient interaction is lost.

The focus of nursing

Eminent nurse theorist Hildegard Peplau remarked that if nursing is the holistic person-centred activity that it believes it is, it must reject the notion of packaging people and their care in relation to medical diagnosis (Barker, 1999, p.46). For example, in relation to diagnosis, many nursing procedures require specific processes to be carried out. Although procedural, it still requires person-centredness and a unique approach to that person. Strict application of a diagnostic and procedural approach alone strives to capture commonality between people whilst diminishing the complexity and variation of people across contexts. Thus, the focus required is on the *meaning* of whatever it was that required care and an understanding of how this changes across the life context for a person and between people. For Peplau, the focus of nursing is interpersonal and constructed between

people in conversation regardless of shared similarities in presentation of a diagnosable condition. Barker emphasises this in his conclusion that 'all people are, in some respects, like all other people, like some other people, like no other person' (1999, p.81) and it is this we must take forward when entering into interpersonal conversations within the context of the medical and psychiatric domain.

With this in mind the focus of nursing and the thread through the thesis is captured quite simply in Peplau's statement; '...it would behove nurses to think exclusively of patients as persons,' (Peplau, 1995, p.2). It captures the fundamental starting point of how we should see another person and emphasises the social construction of nursing and relationships.

Chapter summary

The terrain outlined above is messy, rife with contradictions about how we might approach, define and capture suicide. For nurses, the argument is that there is a responsibility to respond with care yet there is a history of lack of education as the focus has sat within psychiatry and mental health services. How the person is seen, met and responded to is open to debate, depending on where the nurse positions him or herself, the interplay of personal and social discourse and how the discipline of nursing might create a narrative around how we see and respond to suicidal persons. Given the complexity and implicit assumption that nursing is about responding to the needs of a person, it is prudent to consider what is needed to ensure suicidal persons receive care unique to their needs. If nurses are to *see patients as persons* and are engaging in intersubjective discourse as the basis of their role, then the starting point must be a conversation.

Chapter Three

Reviewing the Literature

Search strategies; an ongoing, moveable process

The importance of responding to and engaging with suicidal people in nursing has been explained in the previous chapter. This chapter encompasses the initial review of the literature to highlight a perceived gap in knowledge and to inform the construction of the conceptual framework (Lacey, 2010; Ravitch and Riggan, 2012).

There are notable differences in opinion in relation to engaging with the literature and at what point. Classic grounded theory (Glaser and Straus, 1967) purports that a literature review should be undertaken after analysis of data, whilst others (Lacey, 2010; Ravitch and Riggan, 2012) suggest engagement as part of the development of the conceptual framework and Corbin and Strauss (2008) advise engaging with the literature to guide the theoretical framework. Other grounded theorists (Bryant and Charmaz, 2007; Charmaz, 2014) offer a slightly moveable view of this perspective, advising a balance between using literature for orientation whilst acknowledging pre-conceptions of the researcher. This is indeed the case here given life experiences, current activity and the requirement to complete a research proposal for doctoral study which requires a rationale and initial review of the literature. Therefore, it is the latter perspective of Charmaz which is adopted, providing the rationale for undertaking a narrative review of the literature. Drawing on commentary by Kirkevold, (1997); the Cambell Collabroation (2001, p.3) explain:

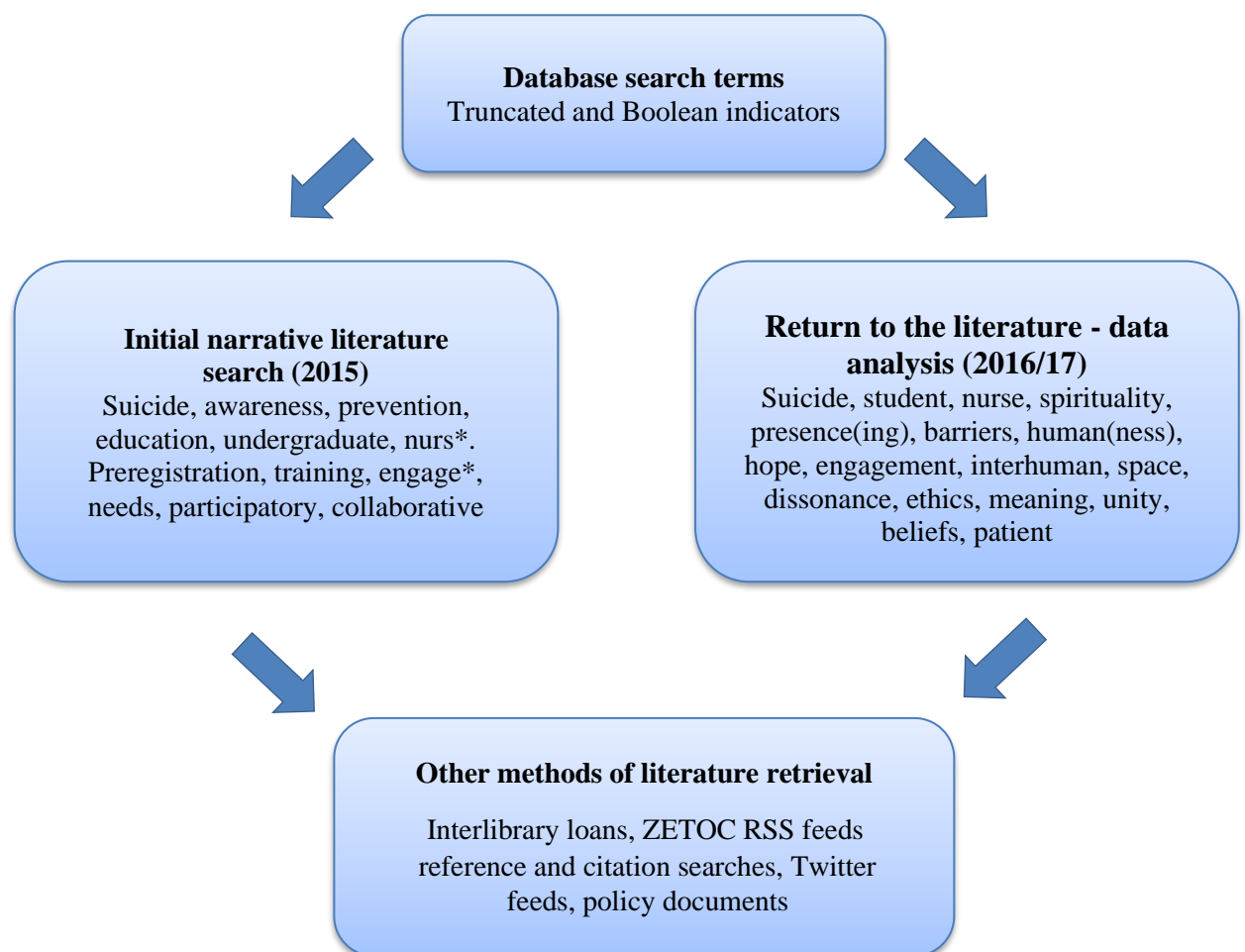
‘...a narrative review summarises different primary studies from which conclusions may be drawn into a holistic interpretation contributed by the reviewers own experience, exisiting theories and models.’

Comprehensive subjects are also considered suited to a narrative literature review (Collins and Fauser, 2005). Both these points are key; the subject of suicide is comprehensive and complex and the literature review was one strand of many from which a gap in knowledge was identified; personal and clinical experience, encounters with the political interface of advisory groups, leading on suicide prevention for the Royal College of Nursing and work as a Trustee, also contributed in identifying the gap in knowledge on which this thesis is based.

A review of the literature was ongoing throughout the study reflecting the iterative nature of the research as described by Charmaz (2014). Extant literature was reviewed after each phase of analysis and as tentative categories emerged, thereby supporting the development of theoretical concepts. As a result, Martin Buber’s teachings (Buber, 1947; 1948; 1955; Kramer, 2012) were adopted with the development of theory from the findings. His work is central to the development of the resulting framework from this research.

A range of sources were used to search for and identify information. Electronic databases were explored since, according to Wu et al. (2012), different index terms and terminology can be used by journals. The electronic databases accessed were: Applied Social Sciences Index Abstract (ASSIA), Cumulative Index to Nursing and Allied Health Professionals (CINAHL), Medline (EBSCOhost), British Nursing Index (BNI), and Web of Knowledge. House of Commons Parliamentary Papers and Department of Health Websites were searched. In addition, interlibrary loans were accessed, ZETOC alerts and RSS feeds were initiated and bibliography searches were completed to follow up key citations (Booth, 2008). Twitter feeds were particularly informative and allowed followup and access to newly-shared information by field experts.

Figure 1. Literature search: Keywords and terms and methods used to retrieve literature



Identifying a gap in knowledge

It is already established from previous knowledge that none of the fields of nursing (with the exception of mental health nursing) are required to undertake competencies in working with suicidal persons prior to registration (NMC, 2010). A review of the grey literature showed an expectation that nurses should be involved in the delivery of the national suicide prevention framework. The narrative literature review demonstrated that a significant proportion of education is focussed on a change in attitude and an increase in knowledge and skills regarding suicide. It is unclear what knowledge and skills are being taught and from whose perspective. This is concerning given the reported attitudes, and limited exploration into what is driving negative attitudes, and how this might affect the quality of a conversation, or indeed the initiation of a conversation, with a suicidal person.

Contribution to, and attendance at various national forums revealed implicit assumptions regarding health care professionals' ability to work with suicidal people. The ongoing assumption was that increasing knowledge and skills in the workforce would encourage engagement and connection and suicidal people will openly discuss their thoughts and feelings. There was an emerging gap in relation to requirements from an individual's point of view; attitudes, knowledge and skill of nurses, focus and variation of education and training and the political focus. Put succinctly, suicidal persons are not confined to mental health services. Nurses are expected to respond to those who are vulnerable, and in need, and preserve safety (NMC, 2015) and take part in the delivery of policy, but only mental health nurses are expected to be competent in responding to those who are suicidal before qualifying. There is also a gap in the provision of education in the UK, across disciplines and internationally. Research shows negative attitudes and an unwillingness to respond to those who are suicidal (this is discussed in the following chapter). Given that the stance of the research is that worlds are socially constructed, both the nurse and suicidal person require consideration in a shared context. *There is little evidence regarding what is needed for student nurses and suicidal persons to engage in conversations about suicide.* Therefore, the following question is posed; what is needed by the suicidal person and the student nurse in order to initiate and engage in conversations about suicide?

Arriving at the research aims, objective and question

Aims

This research focuses on understanding what is needed by self and others (student nurses and suicidal persons) to support initiating and engaging in conversations about suicide and how this may inform nurse education.

Objectives

1. To identify what is needed to engage with the 'other' from the perspective of the student nurse.
2. To identify what is needed to engage with the 'other' from the perspective of the person whom has experience of feeling/being suicidal.

3. To inform application to nurse education about suicide.

Research questions

1. What do student nurses need to engage in meaningful conversations with suicidal persons?
2. What do suicidal persons need to engage in conversations about suicide with nurses and what was helpful to them when they have been suicidal?
3. Using information from the above, how might this apply to nurse education?

The original aim and objectives (below) required reconsideration throughout data collection and constant comparative methods as it became increasingly apparent that it would not be possible to complete in the time scheduled for the Professional Doctorate. Essentially, the aim was slightly changed, objectives four and five were omitted as the research progressed. The first two research questions remained unchanged, and the third question was slightly changed.

Aims

This research focuses on understanding what is needed by self and other (student nurses and suicidal persons) to support initiating and engaging in conversations about suicide and how this may be delivered in education.

Objectives

1. To identify what is needed to engage with the 'other' from the perspective of the student nurse.
2. To identify what is needed to engage with the 'other' from the perspective of the person whom has experience of feeling/being suicidal.
3. To create a co-productive educational session based on the needs identified.
4. To pilot said session with students across all fields on an undergraduate nursing degree programme
5. To evaluate the educational session in relation to addressing needs and preparation for conversations about suicide.

Research questions

1. What do student nurses need to engage in meaningful conversations with suicidal persons?
2. What do suicidal persons need to engage in conversations about suicide with nurses and what has been helpful to them when they have been suicidal?
3. Using information from the above, what would an educational session on the subject look like in undergraduate nursing?

NOTE: it is usual to refer to all whom take part in research as 'participants.' The people who had experience of suicide could not decide what to call themselves collectively and after much humorous debate, arrived at the term 'participants.' In honour of this, 'participants' refers to people from

Launchpad who took part in interviews for this research. Student nurses are referred to as 'student nurses' or 'students' throughout this thesis. The conversations are concerned with nurse-patient conversations.

Chapter summary

This chapter presented the search strategy and initial narrative literature review. Undertaking an initial literature review orientated the researcher and provided consolidation of research questions in conjunction with persona; clinical, charitable and national/political, through identifying a gap in knowledge. Grounded theory research acknowledged the preconceptions of the researcher, emphasising the need for reflexivity, which is embedded throughout the thesis.

The following chapter presents a review of the background and relevant literature. It is important to demonstrate the historical context of nursing and suicide within a social and political context. It also presents the main themes emerging from the literature search on the subject including educational content of suicide in undergraduate programmes and emerging themes from those who are suicidal.

Chapter Four

Review of Background and Relevant Literature

Suicide in space, place and time

This chapter is a review of background and relevant literature of suicide and its connection with nursing. It is important to set the context of the evolving role of suicide in nursing literature including the tensions and philosophical juxtaposition of nursing and biomedical contexts. There is a plethora of available theories and philosophies regarding suicide, too many to do justice within the scope of this thesis. The narrative review of the literature identified themes that impact upon nursing suicidal people, and consequently, the experiences of those who are suicidal. It is appreciated that the subject is wide ranging as nursing is constructed within and throughout many contexts. For this reason, and due to wordage, research including the voices of those bereaved by suicide is deliberately omitted. The subject of bereavement by suicide deserves a specific dedicated space outwith the focus of this work. The voices of those with experience of suicide are included in this chapter, specifically in the final two sections, throughout the findings and discussion chapter and threaded throughout the thesis.

Suicide has occupied space across a diverse continuum throughout history, it has traversed theological, moral and criminal domains, and it is evident in ritual *sati* and undertaken as *pudor* in Roman society. The act of self-accomplished death is shaped and reshaped by those attempting to gain meaning of it and meaning and interpretations are influenced by the prevalent discourse and context of time and place.

Comparing Roman responses to suicide with current epistemological explanations is demonstrative of the changing influences and serves as an important starting point to briefly discuss the evolution of suicide. Self-accomplished death practiced in Roman society challenges current ways of knowing about suicide, namely because it belies the individual psychopathology associated with the act in modern rhetoric. According to Hill (2004, p.2) pressures associated with internal torment, mental illness and hopelessness were not features of self-accomplished death in Roman society, unlike today. Internal torment and modern explanations of suicide are popularly located in the singular, within the individual, with terms such as ‘identity,’ ‘self,’ and ‘personality’ used in Western society to discuss individuals in an abstract way (Marsh, 2010, p.81). Comparatively, Latin writers used terms such as *nos* (‘ourselves’) and *homines* (‘people’), demonstrating little distinction for the individual self. Use of such terms reflects Roman culture, described as highly status conscious and socially orientated; where acts of self-accomplished death were often an incentive to political action or reward of political legitimacy and performed to an audience, as opposed to being carried out in privacy (Hill, 2004, p.10). Marsh draws upon Hill’s observations, stating that the Roman self emerges as ‘purely socially defined’ (Hill, 2014, p.17), remarking that acts of suicide in Roman times can only be understood out-with current notions and presuppositions concerning the autonomy and

individuality of the agent.

Authoritative knowledge throughout cultures, time and place continued to produce variations in the explanation and practice of suicide and, with it, changes in language, for suicide was not a word used in ancient Greek or Roman times. Although suicide is derived from the Latin-based word *suicidium* (meaning killing oneself), the word was not adopted to describe the act of self-determined death in Roman times. The actual term suicide emerged in the seventeenth century. Prior to this, it has been suggested that around 300 expressions in Greek and Latin were used to describe self-inflicted death (van Hoof, 1990) as opposed to a singular word as *suicidium*. This, according to Marsh (2010), is not euphemistic. Moreover the variation in expressions allows for similar acts to be given different meanings. He goes on to explain:

‘...the ubiquitous term ‘suicide’ rather tends to flatten out any such nuances, and we are left with a somewhat impoverished set off resources for constructing meaning around acts of self-accomplished death’ (p.79).

Suicide became synonymous with self-killing and the limiting metaphors and discourse associated with this. Following influencing Roman expressions of self-accomplished death, it is pertinent to briefly consider the influence of Christianity, specifically on Roman Catholic perceptions of suicide. Martyrdom in the aftermath of the death of Christ was a pivotal change regarding the perception of suicide. Marsh refers to the sixth commandment, ‘Thou shalt not kill’ and St Augustine’s ‘deterministic reposition’ of the term to include self-accomplished death as a form of murder. Violation of this commandment positioned the deceased as perpetrator of a mortal sin. Canon laws followed ‘prohibiting self-killing’ and hence self-accomplished death became a form of killing and murder, a sin and a crime (Marsh, 2010) posing a significant shift away from former honourable symbolism. Therefore, terms such as ‘self-killing’, and ‘self-murder’ reflect not only the religio-political orientation but also demonstrate how views began to change regarding the individual subject, reflecting our current perspectives of suicide. With the prevalence of Christian belief, suicide became considered as ‘an intentional, knowing act of the self against the self,’ (Marsh, 2010, p.91), though it is argued that this condemning change of view was misaligned with the moral code of the time. Marsh refers to Murray to explicate this:

‘...men’s [sic] underlying moral conceptions were not at the stage of needing a word for so specific a definition, a definition founded, that is, on a particular compound of intention and act’ (Murray, 1998, pp.39-40).

The impact of the reduction to a single term from a previous plethora of expressions is powerful and unwittingly reduces the quality and significance of the personal experience locating suicide within a subjective/objective domain. Critically, suicide from the seventeenth century begins to occupy a space within and external to the individual. A subject/object spilt occurs that influences how suicide is perceived from the seventeenth century, and a science of suicide emerges as suicide comes to be read as both an individual ‘internal’ phenomenon (arising from within the subject) and one that can

be objectively studied (Marsh, 2010).

The change in how suicide was viewed influenced how authorities responded to suicidal persons. Historians note a period of change of perspective between the seventeenth and nineteenth centuries. During this time, punishable responses to those who were suicidal began to wane as jurors became less likely to punish suicide, and verdicts of *non-compos mentis* increased following verdicts of *felo de se*. A redefined construct of suicide from mortal sin and crime to an act of insanity allowed for further discourses to emerge about suicide and madness, emanating truths about suicide and locating it further into the medical domain. Suicidal persons became separated from criminals and housed in asylums, such confinement made it possible to observe and control groups of people with a view of reformation. Foucault's *Discipline and Punish* (1977) refers to the predicament of the observed and the subsequent constitution of knowledge through surveillance. Here, doctors specialising in medicine of the mind were able to gain knowledge of the suicidal subject through watching, judging and examining. The orderly approach to physical medicine was transferred to the asylum; hence, the medicalisation of suicide began, procedures, notes, diagnosis and treatments ensued, and the suicidal person became the object of scientific enquiry. Suicide was an act caused by a disease as recorded in 1821 by Jean -Etienne Esquirol. Interestingly, at this juncture, Esquirol locates suicide as residing pathologically in the 'internal space' of the individual (Marsh, 2010), and though there was no discovery of pathological anatomy or disease, suicide continued to be claimed under the banner of medicine. This goes some way to explain Minois's (1999) observation that Esquirol's changing perspective of suicide moved from delirium and insanity to anxiety and moral origins. The propensity for suicide was hidden, a private concern that could only be explained by specialist knowledge. Suicide and risk became inextricably linked:

'Madness, as in the case of an impulse of suicide, could be hidden, and detecting insanity became a question of looking for concealed signs of presence. Mental medicine became in some measure the art of reading body for signs of a not yet manifested madness' (Marsh, 2010, p.133).

Concealment was considered cunning and linked with dangerousness hence a threat imposed by insanity on society called for public health control. This gave justification of practice in asylums, necessary observation and restraint to defend society. This positioned psychiatry and mental medicine as powerful determinants and thus, according to Foucault, (2002), the cyclical power and control dynamic served the function of psychiatry.

The combination of concealment, responsibility to society and subsequent recompense from failure to keep people from dying by suicide, meant that risk became a prevalent feature of caring for the mentally ill and suicidal. Although the observation and care of suicidal persons was prescribed by doctors in the asylum, responsibility shifted to the attendant who took over most of the care for suicidal persons, a role later known as the psychiatric nurse. For Foucault (2006), holding patients against their will enacts oppositional relationships of power and resistance. Foucault argues that the

responsibility of suicide in the context of medicine shifts from the suicidal person to the doctor (claiming understanding and creating responsibility to society), to the attendant (delegated responsibility from the doctor). Shepherd and Wright (2002) note in their account of suicide in the Victorian asylum that attendants were subject to demotion or in some cases dismissal if considered to have failed in the prevention of a suicide. Therefore, there are related anxieties in the role of custodian. A hierarchy and constant interplay of power and resistance is enacted where political, social and professional discourses inscribe and territorialise the body of individuals working and residing in psychiatric care. For example, in the case of suicidal persons, an inscription carries requirements that are expected to be fulfilled, such as assuming the role inscribed, compliance with regimes and acceptable behaviour. Resistance to present in this way is constituted as lacking in insight or deviant behaviour. Yet such resistance may be the desire to be different than defined by others (Fox, 1993). The ultimate power of the individual is to attempt suicide (as asserted by a Foucauldian perspective) and act in opposition of containment and prevention. A personal act of de-territorialisation does not shift the power of the gaze but paradoxically enforces it as it goes against the dominant discourse and understanding for that regime. For the suicidal person, these are important sites of resistance that challenge the legitimacy of the prevailing knowledge through which people understand themselves (Burr, 1995). Crucially, resistance asserts the voice of the observed.

The growth of suicide as a science since the nineteenth century has acclaimed certain truths and established suicide within the domain of mental illness and psychiatry. The term *suicidology* is born from ‘the scientific study of suicide and suicide prevention’ (O’Connor, Platt, and Gordon, 2011, p.1) and considered experts in the international field of suicidology champion a wholly scientific approach to researching suicide. Such positivist perspectives crucially lay the foundations for what is considered acceptable and legitimate in relation to reporting and representing what is considered true scientific data. As a result, the landscape becomes dominated with quantitative empirical presentation of suicide. For example, Hjelmeland and Knizek (2010) note that less than 3% of research articles (2005-2007) published in the three main international suicidal journals had used qualitative methods. They relay that the reason for this becomes clear when considering the position of Joiner as editor of *Journal of Suicide and Life-Threatening Behaviour*. Joiner relays a publishing hierarchy where ‘the fully experimental design is advantaged over the quasi experimental ...as will the longitudinal more than the cross sectional, and quantitative more than the qualitative’ (Joiner, 2011, p.471). Qualitative design is at the bottom of the hierarchy vying to be heard. Hence, suicidology is concerned with numbers and scientific rigour with ‘accurate translation of complex phenomena into numbers, numbers then amenable to inferential statistical analysis.’ Joiner continues to impress the importance of such scientific rigour to advance the field of knowledge of suicidology. Marsh (2015) conducts an enlightening critique of the opening chapter of the *International Handbook of Suicidology* by Silverman (2011). Silverman is firmly in the camp of Joiner on a quest for scientific endeavour arguing that reliance on subjective recall of information about suicidality is no

longer acceptable. This focused view subverts the importance of relational understanding of suicide within cultural and historical contexts, as Hjelmeland asserts:

‘Suicidal behaviour always occurs and is embedded within a cultural context and no suicidal act is conducted without reference to the prevailing normative standards and attitudes of a cultural community’ (2010, p.34).

But for Silverman, the ideal goal would be:

‘...a classification system used in oncology... with scales and ranking systems... uniformity of language... suicidal behaviour could thus be read as a form of individual pathology amenable to the sort of categorisation found in ‘mainstream’ medicine which would then inform ‘treatment, management, monitoring and progress’ (2011, p.22).

Marsh demonstrates the associated problems with this approach (see Marsh, 2015) even aside from problems comparing the tangibility, measurability and predictability of outcomes of a tumour as opposed to suicidality. Essentially, Silverman excludes the changeable elements of a person’s life due to immeasurability. Marsh, like Hjelmeland, argues that losing sight of the suicidal process and the changing context of the individual could have effects beyond research:

‘it is often more subjective, contextual and relational factors, by dint of their transience and contingency or changeableness, that allow for hope to be part of any intervention with a suicidal person, and our language should remain open and flexible enough to allow for this to be part of the conversation’ (Marsh, 2015, p.26).

Highlighting such perspectives is crucial to understanding the context and related impact on nursing and suicide. Medical presence is symbolic in the advisory capacity of government, journals, leading research centres, international organisations, influential books and book chapters. The International Handbook of Suicide and Attempted Suicide is dominated by contributions from psychiatrists, psychologists and other doctors and researchers in the field, as Marsh and Hjelmeland point out in their critique and, as such, medicine has set the precedent for its own hierarchy and expertise. With such widespread dominance, medical authority and power becomes embedded into clinical practices and a turn to ‘authority’ to address suicide. There is no space for contribution from nurses within the International Handbook of Suicidology. Nurses find themselves in the position of straddling paradigms, that of psychiatry and psychiatric discourse and the focus of nursing, and as custodian and eliminator of risk. There are gradual moves to increase authority and power of nursing roles, and with the shifting sands of time nurses absorb and aspire to increasingly complex activities focussed around medical interventions. This is reflected in moves by the NMC regarding pharmacology and prescribing for example. The juxtaposition of historical and cultural subordination and current drive for equality is further highlighted by Larkin’s observations. Larkin (1983) refers to nurses recognising doctors as powerful partners and hence nurses negotiate spheres of competence around this.

Challenges with assessing risk

There is a plethora of information available on risk assessment and it can be difficult to gain clarity regarding best practice in this area. The perceived need to complete a risk assessment (to identify risk of suicide), has featured predominantly in psychiatry, although recent studies have refuted the safety, use and predictability of rating scales. A Swedish systematic review (SBU, 2015) concluded that none of the thirteen scales reviewed provided enough evidence to support accuracy of prediction of future suicide. An array of recent studies continues to return similar results of insufficient accuracy in predicating suicidal risk (Chan et al., 2016; Quinliven et al., 2016; Runeson et al., 2017; Steeg et al., 2018). NICE (2011, p.29) clearly state ‘do not use risk assessment tools or scales to predict future suicide or self-harm,’ yet this still occupies a central part of the vocabulary and expectation as part of assessment of the suicidal person. Whereas scales are used to help inform clinical judgement, there is concern of over reliance on the scales or use of them in isolation, as they are perceived as a short-cut exercise to demonstrate the presence of a ‘risk assessment.’ In some cases, the use of risk scales was reported to be significantly worse than clinician assessment, further highlighting the importance of relational aspects and collating narrative accounts of suicide.

Uncovering this information requires investigative research, it is not easy to find; from a nursing perspective, there is no information or guidelines on risk assessment and suicide on notable nursing sites such as the RCN or the NMC. The Royal College of Psychiatrists in contrast offer a myriad of information. The information is not easily uncoverable, as there are layers to wade through and decipher resulting in an unclear approach to risk assessment. There are references to various risk assessment tools from the Royal College of Psychiatrists website. However, according to Bouch and Marshall (2005), there is limited availability of clinically useful methods to assess risk. They add that structured professional judgement and formulation is preferred over unstructured assessment or actuarial assessments (risk assessment instruments used to estimate risk and arrive at the probability of risk in future) (Bouch and Marshall, 2005). Recommendations from the Self Harm and Suicide Report, (Royal College of Psychiatrists, 2010b) advise the doctor to examine the following areas: risk factors, history, ideation/mental state, intent, planning, and formulation. It is interesting to note that none of the information from the Royal College of Psychiatrists’ website presents information on the use of rating scales which features heavily in the research literature as unreliable. Best practice in managing risk (DH, 2007) advocates a multidisciplinary approach and involvement of family and the patient though there is reference to the use of rating scales. The availability of this material as a best practice guide can potentially create confusion within the risk arena.

Continued use of risk scales perhaps gives the illusion of safety and is representative of defensive practice associated with minimising reputational damage of both the clinician and the associated health care employer. Evidence of risk assessment is sought in the event of untoward incidents. This may include gathering information on risk scales and verifying the classification of risk (high,

medium, low), the latter of which is intrinsically unhelpful as such compartmentalisation suggests that risk is static. It also provides a tunnel view of risk when risk is a multifaceted phenomenon.

The Health Ombudsman Report (2018); *Maintaining Momentum: driving improvements in mental health care*, reports on risk assessment and the consequential impact upon safety:

‘The cases below are examples of the impact of poor risk assessment – caused by poor knowledge of illness and the individual context- and the consequences of an unsafe care environment. They are representative of the failings we see in relation to risk assessment, where either a too stringent or too lax approach results in an injustice to the individual and their freedom or safety is compromised’ (p.14).

The report refers to context and makes reference to a ‘too lax or stringent approach’ to risk assessment. This is of course open to interpretation by those undertaking risk assessment and relational risk activities. Observation policies access and egress monitoring, care plans and review of leave from the ward are noted as systemic approaches to risk management (NCIS, 2017).

Extensive work by Bowers highlights staff observation and *engagement* as key; engagement with the person and family problems (Bowers, Banda and Nijman, 2010). In addition, caring vigilance, general inquisitiveness and following up on a sense of unease are noted as important contributing factors on the impact of safety of suicidal persons (Bowers et al., 2011). This takes a whole-person approach to risk and addresses the dynamic nature of people as opposed to rendering the person as static and unidimensional in a fixed space and time. The latter of which is captured in risk scales and prescriptive risk assessment proformas. There is a lack of rhetoric on a caring culture and the importance of service user-led care and family involvement in the dominant risk literature. Research such as Bowers’ does offer encouragement for a potential change in rhetoric. Declan (2018) for example, avers the abandonment of suicide risk assessment, advocating instead for a focus on reducing or tolerating emotional pain.

Risk and intent

Closely linked to risk is the idea of intent. Intent links with the coronial standard of proof and the requirement for coroners to conclude if the person intended to kill themselves before discharging a verdict of suicide. These are criminal standards and appear to interfere with the assessment process of the individual, conflicting with the philosophy of whole person care.

Literature on assessing suicide differentiates between suicidal intent and non-suicidal intent, and nurses and health care professionals are taught to look at the objective signs about what the person said and did to determine intent. According to Freedenthal (2018), those with intent are likely to take precautions of discovery, not tell after hurting themselves, arrange wrapping up of affairs, and write a suicide note. Others refute this, referring to perpetuating myths and stigma and causing confusion about the depth of pain and despair and desire to die in the absence of any of these. This of course is juxtaposed with suicide awareness movements emphatically encouraging those who are feeling

suicidal to seek help. When doing so, those people need to know that they will be taken seriously and not be dismissed as timewasters or unserious about suicide precisely because they have shared. It is crucial to be mindful of the unintended consequences of the success of encouraging help. More people coming forward risks misinterpretation, and a cultural shift is required away from the scrutiny of a biomedical lens and *intent* framework. Affirmation and validation that the person has indeed done the right thing is required. Encouraging those who are suicidal to share may save lives. Waiting for the event to happen is too late to conclude that they were indeed serious. Data from the ONS, (2016, 2017) shows that rates of self-harm are increasing in young people. This is important when considering how this is interpreted. According to Hawton et al. (2005), 'addressing the physical severity of self-harm is not a good indicator of suicidal intent' because adolescents are 'often unaware of the severity of toxicity of substances' (p.893). They suggest establishing intent by gathering information about events leading up to self-harm and exploring concepts of death for the young person.

Suicide, risk and sociological influences

It is necessary briefly to consider sociological influences and explanations of suicide and risk to contextualise nursing as a social phenomenon. Interestingly, at the latter part of the nineteenth century Durkheim's (1897) perspectives of suicide challenged the stance that suicide was solely an internal act of despair. Through his research, Durkheim described how individuals were subject to social forces and therefore this required a sociological explanation. He maintained through his studies that the tendency for suicide was the nature of the individual's relationship with society, not psychological aspects or direct features of the physical environment. The explanation here focusses causation as external to the person and suggests a shared social responsibility to the individual.

Unlike previously-held beliefs about suicide (immoral or disease-based), Durkheim conceptualised a *collective conscience* of society. He posited that suicide was not a phenomenon related purely to the individual (internally-located) but was explainable aetiologically from the social structure in which the individual inhabited (Simpson, 2002). For example, suicidality related to ineffective social bonds and failure of social solidarity. This suggested the need for a strong bond between the individual self and the societal context in which the person operated in order for non-suicidal behaviour to occur. From studying the religious, marital, and political aspects of nations, Durkheim concluded that suicide was explicable by understanding one of three categories: egoistic, altruistic or anomic. Egoistic suicides were individuals who had slight integration into their surrounding family life. Density of family structure and roles played by individuals in the family are considered significant as opposed to family size. Altruistic suicide is representative of greater integration of the individual to society. Here, rigorous governance, either political and/or religious, demand higher command resulting in people taking their own life (Simpson, 2002). Anomic suicide is described as lack of regulation of the individual by society. A propensity to suicide in this category is stimulated

by a change in the norms in which the person has been integrated. Thus, a broadening or contracting of possibilities that are misaligned with the collective conscience causes disturbance in the individual, resulting in possible suicide. Durkheim posits that the categories are not mutually exclusive of one another and can be present for the same individual (ego-anomic, altruistic-anomic and ego-altruistic). Giddens (1991) refers to the consistent representation of dilemmas of living in a modern world, arguing that these 'must be worked through to preserve a coherent narrative of self-identity' (p.188). What is challenged is a concept which Giddens refers to as ontological security, chiming with Durkheim's idea of stability within collective conscience. Giddens refers to the importance of continuity and meaning making in people's lives and the positive view of self and the world in which the person operates to remain ontologically secure. Events that challenge this can result in ontological insecurity, mirroring Durkheim's description of anomic suicide. Durkheim goes on to explain that the situation may be individualised, due to complications given the temperament of the person and circumstances. Douglas (1967) found that what was defined or treated as suicide differed across cultures. This challenged Durkheim's formulation of types of suicide to explain individual suicidal behaviour in society. Self-killing, to self-destroy, or die by one's own hand are other forms of language that exist where the word suicide is not recognised as part of a societal language (Hebrew for example). The language describes an individual act carried out by the 'self,' an entity separate and identifiable from the other.

Although Durkheim's work was considered ground-breaking, and continues to be influential today, critics are keen to point out inconsistencies within it, highlighting limitations of application. According to Maxwell Atkinson's in-depth analysis of Durkheim's work, Durkheim posited that sociology was 'concerned with the study of social facts and that social facts were to be regarded as things' (1978, p.17). Durkheim's work therefore holds positivist assumptions and like the scientific approach of medicine, social phenomena are existing external to the individual and consequently viewed as objective facts to be regarded as things. Though as Maxwell Atkinson purports, social phenomena are inextricably different from objective or natural facts due to their symbolic nature and the subjective interpretations of meaning by individuals. So, what looks to be a leaning towards individual understanding of experience of suicide from a personal standpoint can be distilled into fact since facts have a single meaning that is unchanged for the person or between persons. Hence, the application of numerical techniques to measure social facts relies upon the observer's definition and interpretation of a situation, without knowing how and if this is shared by the subject studied. By viewing suicide in such a way, Durkheim applied positivist theory to search for general laws which explained the fact (suicide) under study. Interestingly this is still observed today with the collection of ONS data.

In a postmodern context, suicide continues to be considered a threat to personal and public safety with theorists looking beyond social structures to explain suicide and risk. The landscape of understanding

is that of complexity. Examination of the literature presents three major conceptions of risk in interplay regarding suicide: risk society, cultural/symbolic and governmentality (Lupton, 2006). Regarding a risk society, simply put modernity cannot depend on social structures to explicate risk because society is fluid, changing continuously in relation to traditional structures and religious makeup. Cultural/symbolic explanations are founded on social expectations and responsibilities and shared understanding, and notions of risk are not individualistic but shared and informed by pre-established cultural beliefs (Lupton, 2006). This is featured in the social constructionist arena as social and cultural processes are influential in determining risk. Therefore, this is a key area of consideration in the determinants of risk as enacted in health cultures and in nursing. Leading authors of these perspectives (Giddens, Beck and Douglas respectively) agree that risk is a political concept used to attribute blame and responsibility (Lupton, 2006). Writing about the current usage of risk, Douglas (1992, p.24) asserts that, 'risk now means danger, high risk means a lot of danger.' Risk has moved beyond the realms of probability and occupies a place in the danger zone. Reflecting upon personal experience, this is poignant. Serious untoward incidents in my clinical practice area were categorised into a hierarchy, with a red zone representing 'catastrophic outcome.' Consequently, the untoward incident becomes unduly associated with a level of fear, and associated anxiety is an inherent part of the undertaking. The clinical incident, for example attempted suicide, becomes part of a wider narrative of risk and danger and a continual threat to personal and public safety.

Suicide and health policy

Twenty-six years ago, the Health of the Nation White Paper was launched (DH, 1992). Key areas identified were reduction of ill health and death caused by mental illness. The government specifically set a target of the reduction in suicide rates by at least 15% by the year 2000. Seven years later, *Saving Lives: Our Healthier Nation* (DH, 1999a) and the *National Service Framework for Mental Health* (DH, 1999b) were published and a reduction in suicide rates was again a key areas for the strategy for England. The latter specifically referring to staff in local health care and social communities as requiring competence in assessing the risk of suicide among individuals deemed to be at greatest risk. A decade after the publication of the White Paper, the *National Suicide Prevention Strategy for England* was launched (DH, 2002) and, within it, the pivotal role of nurses in implementing the strategy was outlined (Anderson and Jenkins, 2006). In their comprehensive paper, Anderson and Jenkins point out that the National Strategy for England and related strategies support ongoing skills development of health care professionals in assessing suicidal behaviour, relaying that the competence of professionals is: 'an essential component of various comprehensive strategies' (p.644). Furthermore, they identify that 'all nurses are directly influenced by the focus of the national suicide prevention strategy' (p.648) and therefore frontline clinical staff require regular up-to-date risk assessment training.

Indeed, there were some encouraging features of policy at the time. There were references to the

implementation of skills based training on risk management (STORM) across England as a key part of the strategy and an evaluation of a six-month study including nursing students and registered nurses indicated an improvement in attitudes towards suicidal people (Gask et al., 2006). It appears that the implementation of these strategies and those thereafter were not unified to create cohesion across pre- and post-registration programmes. The opportunity was lost and the required collaboration between policy writers and those responsible for nursing competencies and education of the future workforce were not realised.

Cutcliffe and Stevenson (2008a) may have argued that the mass training of nurses in skills-based risk management was an opportunity best missed. Their literature review of psychiatric nursing care of suicidal people highlighted the defensiveness and custodial practices contained in policy. They argue there was lack of extant theory to support practices within mental health nursing, in particular referring to defensive practice concerned with meeting organisation needs, sidestepping litigation, concerns with physical containment and little or no reference to decreasing psychache or hopelessness (see Cutcliffe and Stevenson for an in depth analysis of literature). They concur that such risk management strategies were misaligned with the emerging evidence from literature. Cutcliffe and Stevenson critically offer that the emphasis should be on connecting the person with humanity as part of a constructive approach to care as opposed to observation and containment.

Unfortunately, the argument from nurse academics lay dormant and the policy recommendations continued to proliferate without any underlying focus. Ten years on from the White Paper, Preventing Suicide in England; A cross governmental outcomes strategy to save lives (DH, 2012) was published, echoing the goals of previous strategies that remained unrealised. Aside from better support for those bereaved by suicide, it included the need for action to build staff capability in responding to suicidal behaviour and thoughts. Preventing Suicide in England: third progress report of the cross-government outcomes strategy to save lives (DH, 2017) was informed by the Health Committee report (2017). Interestingly, the Health Committee called upon the General Medical Council (GMC), the Royal College of General Practitioners (RCGP) and Health Education England (HEE) to improve training for students and clinicians, although the precise focus of the training is muted. There is a consistent disjoint of a recognised and referenced responsible body for the nursing workforce. The NMC are not mentioned as a 'go-to' for policy alignment and improvement in training.

There is a plethora of policies acknowledging that nurses are key to the delivery of suicide prevention in England. However, this is not naturally subsumed into nursing rhetoric, and nurses are instead politically manoeuvred with little support to implement such directives. Over a decade on from the White Paper, the Public Mental Health Leadership and Workforce Development Framework (PHE, 2015) states that Public Health England: 'Support the development of leaders and a workforce that is confident, competent and committed to preventing mental illness, suicide and self-harm' (2015, p.4). This is further elaborated in the workforce framework as a key competency and priorities for

the workforce include building capacity and capability in suicide prevention.

The document states that suicide prevention training is required in a range of non-mental health professionals to deliver simple brief interventions as well as referral to other services. Community and secondary care staff, health visitors, as well as midwives, and school nurses are identified as the priority workforce. Framework 15, Health Education England's Strategic Framework (2014) also emphasises the development of a workforce strategy that has increased focus on patient experience and dignity and respect, and flexibly trained staff to work across different sectors. This is further embellished in the Five Year Forward View for Mental Health (Independent Mental Health Task Force, 2016, p.76). Suicide is highlighted as a priority along with additional capacity and skills in the workforce:

‘For professions involved in the care and support of people with mental health problems, tailored curricula with competencies in dealing with the common physical health problems people may present with, shared decision-making, mental health prevention (including suicide).’

National drives are couched within the wider health contexts. The global health body, WHO, (2014) recommend ‘training of non-specialised health workers in the assessment and management of suicidal behaviour’ and, in their ‘Preventing Suicide a Global Imperative’ paper, WHO present a framework for public health action in the prevention of suicide (2012). This is interpreted into Local Suicide Prevention Planning in England (PHE, 2016a), a bid to support local authorities to forge a collective response to suicide prevention planning with input from schools, universities, health care services, primary care, voluntary and charitable organisations, police, transport and prison services. This is not dissimilar to compassionate care communities (as advocated by Kellehear, 2013). Compassionate care communities call for joint responsibility in caring for those at the end of their life. At the heart is engaging people across the life span in creative ways to engage with hospices for example. Similarly, Public Health England (2016) advocate suicide prevention as a joint responsibility, moving away from the sole responsibility of mental health services. Given the scope and acknowledgement of input, the implicit assumption is that a community co-ordinated response is required, hence skills are needed to notice and address suicide in the first instance. Local plans encourage the adaption of each area, reflecting the culture and diversity of localities, but there needs to be appropriate representation for the development of suicide prevention plans. Individuals with a position of influence and oversight of the organisation they represent are required to be in attendance if any movement is to occur. Financial implications mean that there may be a postcode lottery to suicide prevention response and at present there is no quality standard for local suicide prevention implementation plans.

WHO provide a plethora of documentation on suicide prevention; a resource series (2000- 2014) is available on their website ranging from information for general physicians to primary care

workers. There is no information specifically for nurses. Reassuringly, there is emphasis on care, warmth and compassion throughout.

The need for the nursing workforce to be rehearsed in noting and responding to suicide continues to be apparent, with 25% of people who die by suicide reported to have a major physical illness, (DH, 2017). This is out-with specialist mental health services and requires nurses and health care practitioners to be cognisant of the possibility of suicide within their work arena. The report continues to suggest that the education of GP and surgery staff is a crucial role in suicide prevention. There is a legitimate argument that children and adult nurses require knowledge and skills to respond to young people who self-harm and voice suicidal thoughts. The same report identified the highest prevalence to be girls under the age of seventeen admitted to hospital due to self-harm. Suicide is also recorded as a leading cause of death in pregnant women and new mothers (MBRRACE-UK, 2015), demonstrating the necessity for midwives and health visitors to be aware of suicide in order to notice and address perinatal mental health.

National variation

The national governmental picture is varied, with the Welsh government (2015) investing in the Talk 2 Me strategy until 2020. This sends a clear message that suicide cannot be tackled by one single organisation. It is cross-sectorial and collaborative. The Northern Ireland strategy for suicide prevention (Protect Life 2) is published in draft format (DHNI, 2016). Scotland have recently launched an engagement paper on future suicide prevention plans (Scottish Government, 2018). This is a key summary document referring to outcomes from previous national strategies and refers to modernising content and accessibility and sustainability of training. Notable is the lack of evaluation of the efficacy of the last training plan which featured Applied Suicide Intervention Skills Training (ASIST) (Living Works, 2018). It was adopted as part of the key strategy for educating staff, featuring heavily across nurse training in Scotland (Evans and Price, 2013) and filtering into other professional fields. Educational strategies on suicide rarely report research follow-up outcomes such as referencing efficacy of programmes six months on.

Guidelines

The publication of Preventing Suicide in Community and Custodial Settings: information, advice, education and training by NICE (Draft Feb, 2018) essentially summarises workstreams by Public Health England, Health Education England, advisory work from the National Suicide Prevention Advisory Group and committed charities about suicide. Disappointingly, there is no clinical guidance for best practice. It does provide a review of suicide awareness and prevention training concluding that there is little evidence of the effectiveness of specific training programmes (emerging examples are captured in a joint produced document entitled Mental Health Promotion and Prevention Training (PHE, 2016b).

Of note are comments about limited follow up post-training and an expectation that training could be expensive but it was still expected to form part of continual professional development work in professional groups. There was a suggestion that gatekeeper training should be undertaken though there is no consistency of exactly what training package this should be. This is understandably difficult to commit to with the lack of efficacy referred to above.

From 1992- 2018, it is prudent to say that the rhetoric of suicide awareness and prevention has grown exponentially, and there is recognition of a community approach to suicide expanding boundaries of health services into schools, charities and public sector services. Crucially, over the last 26 years the formal education of suicide as a nursing competency has featured only in mental health nursing. This is despite the plethora of policy focussing on suicide prevention and the nursing workforce.

Educational content in preregistration nurse education

The lack of information regarding the educational content of suicide in undergraduate educational programmes in the UK poses an interesting observation given the abundance of policy references to nursing and the pivotal role of nurses in implementing the national suicide prevention strategy (as noted by Anderson and Jenkins, 2006). Additionally, the international literature regarding education in suicide awareness and prevention in nurse education is limited (Gask et al., 2006; Nebhiani et al., 2013; Pederson, 1993; Pullen et al., 2016; Scheckel and Nelson, 2014; Sun et al., 2011; Heyman et al., 2015). There is also a reported gap of formal training received by people working with those who are potentially suicidal when searching across disciplines, (Palmierie et al., 2008; Dexter-Mazza and Freeman, 2003). An America study (Feldman and Freedenthal, 2006) reported that no training was received by social workers during their undergraduate course (n=600). In a review of the literature, Schmsitz, et al. (2012) reported that 6% of counsellors and 50% of psychologists reported receiving training in suicide risk assessment in America.

The American Psychiatric Nurses Association (APNA) responded to the request of members calling for best practice and education regarding working with suicidal people. Suicide awareness was recognised as a core role for nurses, but no competencies were available for registered psychiatric nurses. In their position statement, APNA's Board of Directors proposed to develop core competencies for nurses to address serious gaps in education (APNA, 2015). Since then, APNA have committed to modifying competencies to disseminate delivery in a variety of healthcare settings including medical surgical areas and other areas out-with psychiatric and mental health nursing.

A literature review revealed research specifically addressing suicide awareness and prevention training in undergraduate nurse education (Gask et al., 2006; Nebhiani et al., 2013; Pederson, 1993; Pullen et al., 2016; Scheckel and Nelson., 2014; Sun et al., 2011; Heyman et al., 2015). It

ranges from delivering 4-hour bespoke suicide awareness programmes (Sun et al., 2011) to evaluation of established gatekeeper training (Heyman, et al., 2015; Pullman et al., 2016) and interpreting experiences of student nurses caring for suicidal persons (Scheckel and Nelson, 2014). Interestingly, systematic reviews conducted by Isaac et al. (2009) and Mann et al. (2005) concluded that gatekeeper training was good for building knowledge and skills and moulding attitudes of trainees and that gatekeeping was a promising strategy for health care professionals. This was echoed in a multimethod study (Pullen et al., 2016) of senior student nurses' response to the Question, Persuade, Refer (QPR) gatekeeper programme in the USA (n=150). This comprised pre- and post-test instruction looking at self-appraisal, knowledge, skills, and abilities. There was a reported significant increase in both understanding and comfort level of asking about suicide after QPR training. Students reported increased feelings of capability to intervene with persons at risk of suicide. The authors recommended further evaluation of programmes in pre-registration nurse education, especially in ethnically and culturally diverse areas. All studies concluded positively, suggesting the need for research into long-term follow up to elucidate impact. When consulting literature in post-registration nurse education, similar themes are apparent. A qualitative evaluation of an 18-hour suicide prevention programme with general nurses measured changes in knowledge, attitudes and competence on the management of suicidal people. The nurses previously reported lack of empathy and knowledge, and voiced hostility towards suicidal others (Chan et al., 2009). The study took place in Hong Kong over two hospitals and qualitative data was collected via a focus group with 54 nurses. Results suggested that an 18-hour training programme had improved attitudes of working with suicidal people, and that there was self- perceived competence and increased awareness of suicide. However, there is no reference to longitudinal follow up for observed maintenance of attitude change. There is limited understanding of the efficacy of attitude change with some of the quoted educational programmes and maintenance of positive changes in stressful and demanding environments.

Similarly, a Swedish study by Samuelsson and Asberg (2002) measured changes in attitudes of psychiatric nurses towards people who had attempted suicide. The aim was to evaluate short-term effects of suicide prevention education for psychiatric nurses. After 36 hours of teaching, the results were tentative, although changes demonstrated more willingness to help and increased understanding and better assessment of risk. This is questionable since it relies on the researcher's interpretation of what the outcome should be. There was a perceived need for further training, as the modified internal validation scale fell just short of the accepted internal validity score (0.69 as opposed to 0.7), and there were no further recommendations. This suggests that training in isolation was limited in this example.

Tsai et al. (2011) implemented a brief instructional intervention suicide awareness programme (90 minutes duration) to 195 nurses in Taiwan as part of continuous education training. Results

demonstrated an increase in awareness of warning signs and an increase in reported willingness to refer patients for follow up. It did not explore the desired outcome for the patient or the need to refer if the interaction was positive from the outset.

Other studies (Herron et al., 2001; Samuelsson and Asberg, 2002; Botega, et al., 2007; Shim and Compton, 2010; Gask et al., 2006; Chan et al., 2008) report suicide prevention training having a positive outcome on health care professional's perception of working with suicidal people. Interestingly, research undertaken by Ramberg et al. (2016) in Stockholm, concluded that attitude improvement towards suicide prevention may be linked to role clarity. They also reported that education was likely to improve attitude, therefore improving clarity regarding role in the care of the suicidal person and general confidence in prevention.

Although training approaches are generally positively received and reported in the literature, key findings conclude that more research is needed to evaluate the efficacy of suicide prevention programmes (Heyman, Webster & Tee 2015; Zalsman et al., 2016). The lasting impact of receiving training is unknown, suggesting the need for mandatory refresher training to be built into delivery plans.

Pre-registration nurse education and the position of the Nursing and Midwifery Council

Echoing the need for skills and capability identified by Health Education England and aforementioned in Preventing Suicide in England (DH, 2012), Cutcliffe and Stevenson (2008b) authored a two-part paper aptly named 'Never the twain? Reconciling national suicide prevention strategies with the practice educational, and policy needs of mental health nurses.' They argue for a move away from surveillance and defensive practice to encourage inspiring practice and co-presencing with others and a focus on the ability and capacity of mental health nurses to engage with suicidal people. The authors advocate an introduction to caring for suicidal others in preregistration nursing.

Despite such best hopes and intentions in a plethora of policies over two decades ago, it appears that the implementation of suicide prevention strategies and workforce preparation were not unified to create cohesion across pre- and post-registration programmes or workforce development in England. What has resulted is significant rhetoric with limited outcome. As a result, professional development and education of suicide has remained stagnant with the initial policy tenets unrealised. The essential stakeholders were missing from the table. Collaboration between policy writers and the Nursing and Midwifery Council were essential, with the latter responsible for creating nursing competencies for the future workforce. The NMC realistically hold power as guardians of nursing standards. Equally, timing is crucial, for during the last two years the proficiencies for the standards of pre-registration nurse education have undertaken an in-depth consultation and review. Despite ongoing influence and campaigns to include proficiencies for suicide across all fields, the standard was omitted from the

published draft standards post-consultation, leaving a worrying disconnect between nurse education, national policy and a growing evidence base around suicide. However, the momentum gained in suicide awareness and prevention in nurse education was reaped and re-sown (see Appendix 3) and the proficiencies were reintroduced. The Future Nurse Standards (NMC, 2018) refer specifically to suicide and self-harm for all student nurses:

Platform 3 assessing needs and planning care:

3.10 'demonstrate the skills and abilities required to recognise and assess people who show signs of self-harm and/or suicidal ideation' (p.15)

Annexe A; communication and relationship management skills

1.7 be aware of own unconscious bias in communication encounters (p.28)

2.9 engage in difficult conversations, including breaking bad news and support people who are feeling emotionally or physically vulnerable or in distress, conveying compassion and sensitivity (p.29)

Inclusion of this is an eventual alignment with the rhetoric through policy over twenty-six years. It also ossifies the tenets implicit in The Code of Conduct for Nursing and Midwifery (NMC, 2015), and aligns with plans for suicide prevention training in medical education (GMC, 2017). This will hopefully merge a collective response to recognising and responding to suicide, and the nursing community response should be that of care and consideration of the emerging evidence base around human needs when caring for suicidal people. Once more, time is of the essence. The RCN motion was passed in 2014. The Future Nurse; standards of proficiency for registered nurses (NMC, 2018) are not due to be enacted until 2019 and current curricula still honour the existing standards. It is reasonable to conclude that student nurses will not be exposed to the concept of responding to suicidal persons until between 2020 and 2022. An unnecessary slow, laboured and embryonic process in its realisation nearly 30 years on from the White Paper of 1992.

And this is just the beginning. From here, educational institutions are required to provide evidence-based practice. As touched upon in the section above (nurse education) little is understood regarding patient experience and the subsequent impact on therapeutic engagement and quality experiences after training is received as viewed by those in receipt of care. Although training approaches are generally positively received and reported to impact upon knowledge and attitudes in the literature, key findings conclude that more research is needed to evaluate the efficacy of suicide prevention programmes (Heyman et al., 2015; Zalsman et al., 2016). This is a monumental challenge for several reasons. Firstly, it is necessary to define efficacy. NICE (2018) draft guidelines on suicide in the community and custodial settings refer to a future decrease in the number of suicides reported (as per ONS figures) as demonstrative of effective education and intervention. This is problematic on several levels. Reasons for a reduction in recorded suicides may be multifactorial and not solely a response of education and training. Given the brevity of the interaction with suicidal others in both formal and informal contexts, outcomes may not always be known as such fluidity does not capture outcomes of

the intervention unless every intervention is followed up. There is also the concept of efficacy. From the point of the recipient of the education, efficacy captured at the point of exit from the training programme has shown to be positive, though it could be a case of any information being useful in a void of suicide talk. Additionally, longitudinal follow up is limited.

Careful consideration of training delivery is necessary to avoid the tick-box application that we strive to avoid in practice. There is a need for appreciation of the complexity that sits behind attending and delivering programmes. There is not one advocated delivery package and there appears to be little evidence underpinning the actual methods of delivery (Heyman et al., 2015).

Prejudgement and prevailing attitudes

International studies reveal re-occurring themes of negative attitudes and pre-judgement from nursing staff working with suicidal people. Nurses working in an Emergency Department (ED) in Brazil considered suicide to be impenetrable and unjustifiable behaviour, reporting it not to be of their own choice to care for those who were suicidal (Vedana et al., 2017). Of a similar vein, a cross-sectional survey study in India (Nebhiani et al., 2013a) explored nursing students' attitudes to suicide prevention and revealed that suicide was considered to be attention-seeking behaviour. Comments included that those who were serious about suicide would not tell anyone, suicide was endorsed as a right and subsequent preventative measure were considered to be minimal as suicide was equated to poverty and unemployment, hence it was unavoidable and indicative of circumstances. A further descriptive study by the same author researched nursing students' attitudes towards those who had attempted suicide and revealed that students believed suicidal others were mentally ill, weak, rigid and, in addition, were non-believers of the afterlife (Nebhiani et al., 2013b). Rarely do research studies report upon the cultural context of research but it is prudent to consider the potential of religious, spiritual and cultural influences permeating the decisions and attitudes of the nurses in the study. Hinduism and Buddhism are the main religious influences in India, both pertaining strong beliefs in afterlife and reincarnation. Sun et al. (2011) refer to the importance of gaining longitudinal outcomes of their study with reference to cultural beliefs in the context of their research. The quasi-experimental investigation in Taiwan with second-year students (n=174) showed that a 4-hour suicide awareness programme increased awareness and promotion of positive caring attitudes in the experimental group (n=95) as opposed to the control group. The need for longitudinal follow up was emphasised due to the potential of initial positive results being negated over time as suicide is considered morally wrong in Chinese culture. The person who suicided is not able to care for family as rooted in the teachings of Confucius.

A review of the literature so far has demonstrated a multifactorial and complex picture, notwithstanding that most studies are concerned with the care givers' experience and reports demonstrate concern with needs of self rather than that of the person who is suicidal. More revealing studies offering insight and depth help understand the complexities situated around lack of

engagement. As Cutcliffe and Stevenson (2008b) emphasise, there are huge demands on the wellbeing of the carer who is actively engaging with the suicidal person rather than observing from a distance. Greater understanding is needed regarding the feelings and reactions of nurses working with suicidal people, first to move beyond avoidance to engagement and secondly to acknowledge that active engagement has huge demands on the wellbeing of the nurse, including negative impacts (Cutcliffe and Barker, 2002; Duffy, 1995).

The struggle to care

Beyond general reports of gatekeeper training and attitudinal changes, a few studies note specific emotional responses to working with suicidal people. Scheckel and Nelson (2014) researched nursing students' experience of caring for suicidal people (n=12) in an interpretative study. Three main themes emerged that affected interaction with suicidal others, including the arousal of fear when learning that someone is suicidal from patient notes. Secondly, gathering risk information was influenced by how much the person talked to them and offering safe intervention was impacted by critical thinking in the context of the assessment. Hence, the students struggled with eliciting information if it was not offered since they were fearful and concerned with completing their assessment. The authors conclude pedagogic consideration for ongoing teaching of suicide assessments. An earlier American study conducted by Robinson-Smith et al. (2009) partially addresses this pedagogic recommendation. Students (n=112) reported improved critical thinking skills and perceived self confidence in completing suicide risk assessment and mental state examination after simulation exercises. This is reflected in findings by Heyman et al. (2015) who evaluated 2nd-year pre-registration nurses' experience of an acquired suicide intervention skills training programme (ASIST). Students reported that participation was emotionally challenging though confidence was gained through role play and reflection. These studies indicate as the researchers suggest, that the environment for learning is just as important as the material being taught. Although Scheckel and Nelsons' study is small it adds an important perspective for consideration and exploration; the knowledge of dealing with a suicidal person evokes fear and related emotional responses thus impacting upon the ability of the nurse to connect and elicit information. Findings bound up with emotions move beyond preregistration nursing and across health care settings. An analysis of oncology nurses' barriers to suicide risk management to improve interventions and management of suicidal people was undertaken (Valente, 2011). Qualitative data analysis revealed communication barriers, concerns about what to say, judgment of suicide (what is morally right with personal religious views), unresolved grief and fear. Finally, inadequate knowledge was cited. This substantiates claims that working with suicidal persons is emotionally intensive and complex.

A Norwegian study researched psychiatric nurses' (n=19) responses to working with suicidal people in an inpatient unit (Gilje et al., 2005). A category of 'struggling with self and sufferer' emerged. Boundary issues were deemed as significant within this, particularly regarding the struggle between

being close and being distant at the same time. They uncovered that nurses offered compassion without feeling. This is described as the intellectual application of being compassionate. The nurses said the words pertaining to compassionate care but were not identifying with the situation at hand.

Wilstrand et al. (2007) interviewed six psychiatric nurses in a Swedish hospital regarding their experiences of caring for patients who self-harm. Although limited in application, similar themes arise which have been mentioned above. This included fear, abandonment and frustration in relation to balancing professional boundaries. Importantly, these studies touch upon the reaction of the nurse and, as Gilje et al. (2005) offer, deep self-reflections and existential issues are highlighted as disclosures in their research and suggest that such knowledge is made visible in the nursing literature. Such findings go to the heart of the subject and move beyond attitudinal explanations; the focus of many of the research papers. Talseth et al. (1997) examined narratives of nurses caring for suicidal patients. The main themes identified included distancing with subthemes of mistrust, feelings of guilt about the person's attempt, compassion without emotional identification and focusing on self rather than the patient. The second key theme was closeness, which included building trust, setting one's own agenda for care, listening, and compassion with emotional identification. In this category, nurses focused on patients rather than themselves. Interestingly, the notion of rejection was significant, whereby nurses either rejected patients or felt rejected by patients.

Finding connection

Cutcliffe et al., (2006) completed a modified grounded theory study of how psychiatric nurses work with suicidal people from the voices of those who were suicidal. They concluded on a three-stage healing process: 'reflecting an image of humanity, guiding the individual back to humanity, and learning to live.' The core variable was 'reconnecting the person with humanity.' Stage 1 of 'reflecting an image of humanity' consisted of the nurse communicating to the person that they somehow mattered. This had a 'profound effect' consisting of warm, care-based nursing contact and the warmth of the nurse acted as a draw to life. Other core elements were being prepared to listen and talk about feelings. Entering the space by the person in distress was gradual, as the person sought permission, weighed up the authenticity of the nurse, and sought qualities such as kindness, care and warmth. Stage 2 was termed 'guiding the individual back to humanity.' This was characterised by a different activity; here the nurses offered a 'renewed insight.' Consequently, the person gained control over suicidal feelings, there was a shift in focus, and the person reframed their situation and uncovered a sense of hope. This paper articulates depth, meaning and complexity and highlights the skills requirement of a nurse to recognise how to interact at specific junctures. In-depth findings reflecting human connections were also uncovered in Vatne and Naden's study (2016), whereby positive connections with professionals were important in instilling hope and helping the person to become aware of their desire to live. The authors reiterate the importance of connecting and experiencing someone who cares as necessary for life when working with suicidal persons. Similar themes are

noted in extant literature of the need for connecting the person back to humanity through the therapeutic interaction (Cutcliffe et al., 2007; Sun et al., 2006). Connecting, according to the suicidal person, requires presence. Cutcliffe et al. (2008b) share the therapeutic value of co-presencing with suicidal others with findings from Talseth et al. (1997, 1999), with the latter authors specifically noting that people can only co-presence if they are comfortable with discussing death and suicide. Both highlight micro skills and the complexity of interpersonal communication as key.

Disconnection

The term engagement is highlighted throughout the literature as key, although it is not fully conceptualised. Lees et al. (2014) gained information via questionnaires and interviews from patients and nurses regarding their experiences of suicide and explored engagement as a key area. Patients reported that engagement was crucial though this was not always experienced. Conversely, a lack of therapeutic engagement, self-awareness and reflective practice associated with diminished motivation to engage was uncovered from data. Negative attitudes and medical and custodial interventions featured prominently. Lack of training and education were also cited as areas of concern. Practical conclusions from the research were orientated to education, supervision and support and the need for therapeutic engagement and development. Four key concepts in understanding nurses' responses to suicidal people emerged from a critical interpretive synthesis of the literature (1998-2009) and reflect the findings here. Additional areas identified were: a need for critical reflection, change in attitude, complex knowledge/professional role responsibility, and a desire for support/resources to help engage with suicidal people (Talseth and Gilje, 2011). Dunkley et al., (2017) relay that feedback from suicidal persons is that they experience a one-size-fits-all response to care, resulting in a misalignment between staff behaviour and patient expectation. Vatne and Naden's (2014) earlier findings concur, proffering that in some cases encounters with health care personnel can be unhelpful, diminishing hope and reinforcing suffering.

Chapter summary

The review of relevant literature has presented several key aspects pertinent to the nature of the thesis. It is necessary to present historical factors and the changing presentation of suicide to understand the historical and cultural context of nursing and suicide.

From the cited ritualistic expression of self-killing in Roman society to custodial asylums and the current health care climate, nurses have inherited a responsibility for the safety of suicidal persons, ossified by policy and social expectation. Surprisingly, there is no consistency in the national approach or policy in education, or indeed across the nursing profession, regarding how this is best achieved with the needs of suicidal persons at the core. The implicit assumption is that nurses are concerned with what it means to be human in moments of strength and despair, and will respond to this. Whereas this may be the case for many nurses, the review of the literature reveals fear, negative

attitudes and a lack of knowledge and skills to craft a meaningful response to those who are suicidal. Moral and ethical tensions within cultural contexts highlight significant areas of tension along with a lack of reflection and self-awareness. Expecting nurses to inherently connect with a suicidal person becomes less of a certainty given the information uncovered by research and presented above. The landscape is multifaceted, beyond the delivery of demographic facts and figures and risk profiles. What is clear is the participatory nature of nurses in co-constructing a desired experience with suicidal people and, with this, a responsibility to support nurses to acknowledge personal fears and attitudes to suicide through appropriate education and reflection.

Little is understood regarding a suicidal person's experience and the subsequent impact on the quality of engagement after training is received by the nurse. Those who have been in receipt of interventions when suicidal relay the need for human-to-human meaningful contact. Soul-less information gathering serves as a barrier to connecting with the person; an empiricist perspective that suicidality represents an objective reality that can be measured and observed. Therefore, just as interactions need to be based in meaning to be effective, one could argue so does the framework in which education is delivered (Rebair, 2018).

The following chapter presents the conceptual and theoretical framework of which this thesis is housed. The framework represents philosophical, ideological and theoretical perspectives giving meaning and basis for the research.

Chapter Five

Developing the Conceptual Framework

This chapter addresses the overall conceptual framework and components of the research incorporating the associated philosophical paradigm and epistemological and ontological tenets. The underpinning theoretical perspective of symbolic interactionism and social constructionism follow. The methodology of constructivist grounded theory is discussed whilst the actual methods applied are described in chapter six. Whilst it is noted that the preceding chapters relate to discrete parts of the conceptual framework (curiosity leading to research gap/problem, formulating the research questions), it is important to acknowledge the fluidity of the process between component parts (see figure 2 below). Note the bidirectional arrows, as these depict the inter-relationship and fluidity between exploring the need for research, the research question and the research strategy. The conceptual framework as depicted here is more than the sum of its component parts.

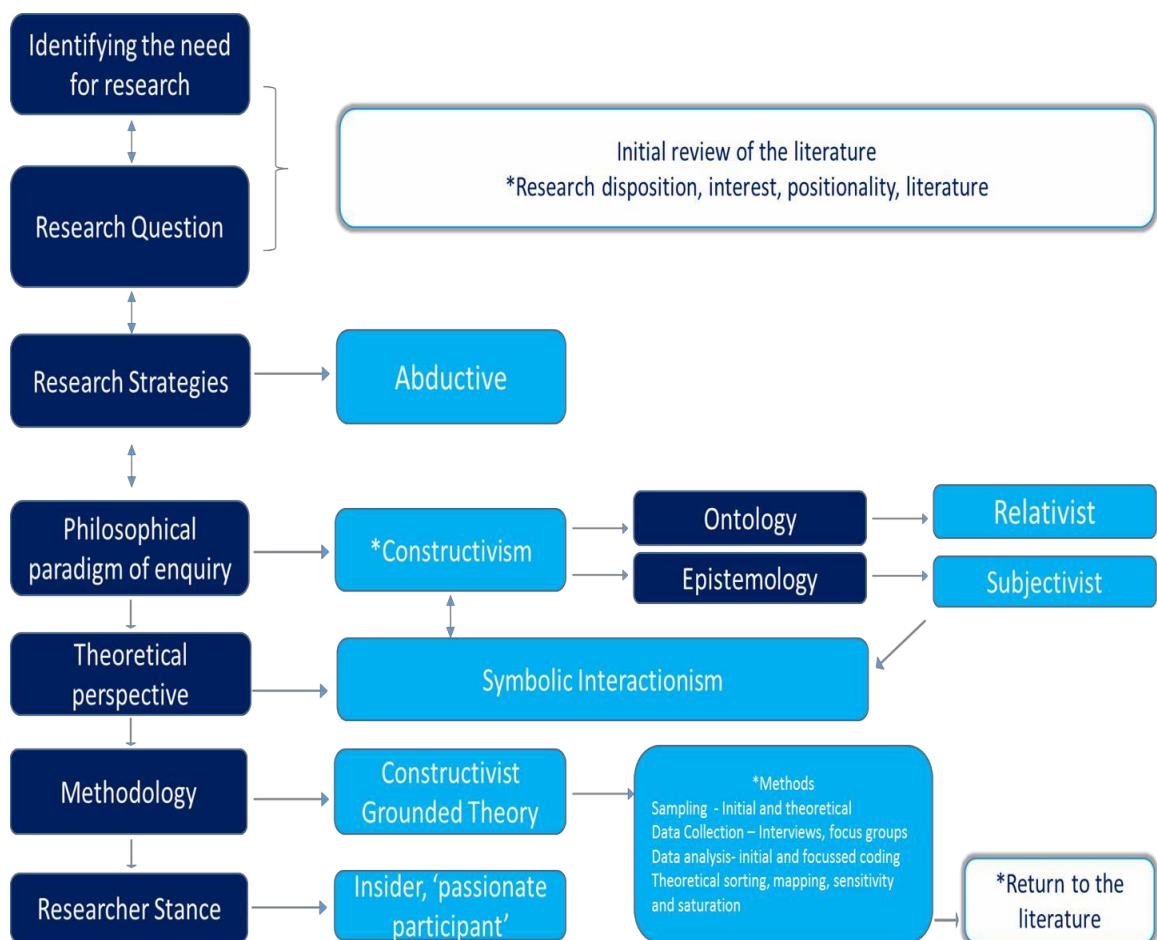
According to authors (Green, 2013; Ravitch and Riggan, 2012), information regarding the conceptual framework is obscured in the research literature, lost in various translations and set alongside concepts of theoretical frameworks. Green purports that the terms conceptual and theoretical frameworks are used interchangeably throughout the literature without reliable commonality in the interpretation of the meaning. In addition, the point is made that some researchers do not articulate if either have been used in the research design or, if so, do not differentiate or stipulate to which they refer. For the purposes of the thesis, I have adopted the interpretation of Lacey (2010) and Ravitch and Riggan (2012). Lacey states that the conceptual framework is concerned with the researcher's world view and therefore his/her assumptions and preconceptions are delineated across the areas studied (Lacey, 2010). Due to the constructive nature of the framework, it requires the acknowledgment of the researcher's positionality and transparency regarding how this will significantly influence data interpretation and findings. Presentation of this is considered essential for the credibility of the research (Miles and Huberman, 1994; Ravitch and Riggan, 2012). Ravitch and Riggan emphasise this point, relaying that the conceptual framework is a guide for research and allows the researcher to explore research questions in a new context or research unexplored areas, thereby supporting the generation of further knowledge. They further purport that the conceptual framework supports the researcher to make defensible, informed and reasoned choices about how to undertake research by supporting the alignment of analytic tools and methods to the research question posed. With this in place, the researcher is guided in relation to how data is collected, analysed, described and interpreted. So, for Ravitch and Riggan, the characteristics of the conceptual framework are shared with that of Miles and Huberman (1994) and Maxwell (2005), and are a tool for learning and a way of linking all the elements of the research process. These are: 'research disposition, interest, and positionality, literature, theory and methods' (Ravitch and Riggan, 2012, p.6). Importantly, they stipulate that the interrelationship between three primary elements (personal

interests, topical research and theoretical framework) comprise the conceptual framework, supporting learning from others and cultivating personal knowledge and perspective throughout the duration of the research process.

The theoretical framework is a key component of the conceptual framework, not mutually exclusive. Ravitch and Riggan summarise that ‘topical research describes the ‘what’ of the study, while theoretical frameworks clarify the why and how’ (2012, p.13). The theoretical framework is discussed later in the chapter. The development of a conceptual framework is therefore core to shaping and implementing research. It is constructed by the researcher and is a product of an evolving iterative processes whereby philosophical, theoretical and ideological perspectives are supported and challenged throughout the research process, offering insight into the researcher’s perspective of the social world (Miles and Huberman, 1994; Maxwell, 2005; Ravitch and Riggan, 2012). The conceptual framework underpinning this thesis evolved through an ongoing iterative process, subject to review, reflection and change as knowledge was gained and the research process experienced.

Figure 2. Overview of the conceptual framework and research approach.

* Refers to Lacey (2010) Ravitch and Riggan (2012), Charmaz, (2014)



Philosophical perspectives

By adopting a reflexive approach, the researcher is called to examine how they view the world. Importantly, this influences the adoption of a particular research paradigm, a basic set of beliefs that guide action (Guba, 1990), which in turn influences the approach to social enquiry because integral to each paradigm are ontological assumptions (concerned with the nature of what exists, what can be known) and epistemological assumptions (concerned with the nature of knowledge and how it can be known). As methodology is influenced by both ontology and epistemology the most appropriate methodological approach is taken to answer the nature of the research question. Reflexivity and transparency from the researcher acknowledge bias or misalignment between world view and appropriate methodology.

Traditionally, philosophical accounts of the nature of reality have been addressed and presented in two discreet and opposing areas; that of positivism and interpretivism. These terms tend to be crudely associated with the production of numeric information in the former or narrative information (latter) as an answer to a query about the nature of reality (Fossey et al., 2002). Broadly stated, positivist approaches to social inquiry are concerned with the *explanation* of human behaviour derived through application of methods from the natural sciences and the understanding that there is a social and natural world out there to be discovered. In this paradigm, researchers study the social and natural world objectively, creating and testing concepts and theories as the assumption is that reality exists *apart from* and *independent to* the observer. It is purported that the explanation of social behaviour can be conducted by the researcher in an objective or value-free manner given that the researcher is independent to an external, measurable reality. Theories are deduced, challenged or created from observation. Social phenomena are considered to be measurable through outsider observation and generalisable to naturalistic laws, therefore the theory tested is logico-deductive. This approach is juxtaposed to the presentation of the phenomena of suicide and nursing in the previous chapter and initial sharing of my world view.

Interpretivism

The ontological stance of this research sits within the relativist domain. Relativism assumes *what can be known* about the nature of reality is constructed intersubjectively and the meanings and understandings are formed socially and experientially. Knowledge is local and specific and consists of constructed and co-constructed realities (Denzin and Lincoln, 2005).

Subjectivist epistemology (how social reality can be known) is addressed through the epistemological stance of subjectivism. Subjectivism differs from objectivism featured in positivist approaches, as the latter pertains to a separate world that exists out-with the researcher, therefore interpretations are of something existing apart from the individual and views are objective.

Conversely in subjectivism, the existence of the individual is key as the researcher and participants are inextricably linked in the process and creation of findings. How we understand the world is central to how we understand the self and others.

Interpretivism is concerned with the study of social phenomena and gaining an *understanding* of the social world people have constructed (Blaikie, 2007; Bryman, 2008). Interpretivism inducts theory through studying interpretation of social events from the assumption that reality is not a fixed entity waiting to be discovered. Moreover it is considered to be a fluid and dynamic process constructed by individuals interpreting and reinterpreting their understanding of the world. This constant process of interpretation and reinterpretation of the actions of self and others produces meaning and people act based on this meaning, producing social action. Therefore, interpretivist methodologies aim to understand social reality grounded in the subjective experience of meaning (Hughes and Sharrock, 1997). However, generalising in two distinct paradigms limits the range and complexity of the various philosophies of world views, with some authors keen to emphasise that positivist and interpretivist paradigms are not in opposition but part of a continuum of classical paradigms and approaches to research ranging from positivism to critical rationalism, classical hermeneutics and interpretivism (Blaikie, 2007; Blaikie; 2010; Bryman, 2008). Contrastingly, other authors identify positivism, post-positivism, critical theory and constructivism as the main range of paradigms in qualitative research (Guba and Lincoln 1994; Denzin and Lincoln, 2005); or refer to positivism and constructivism as opposing theoretical positions (Gray, 2014). Unsurprisingly, this creates a confusing landscape from which to construct a conceptual framework as specific to each paradigm are ontological and epistemological assumptions that bear relationship to each other and will impact upon the kind of research outcomes achieved depending upon the stance adopted by the researcher in a bid to address the research question posed (Blaikie, 2007; Denzin and Lincoln, 2005). The position adopted for this research is that identified by Guba and Lincoln (1994) and Denzin and Lincoln (2005) and located in interpretivism. The paradigm of inquiry is constructivism with a relativist ontology and subjectivist epistemology.

Theoretical Perspective - Symbolic Interactionism

The foundations of symbolic interactionism are rooted in pragmatism, a philosophical perspective suggesting that people come to know the world through deriving meaning through action. Pragmatists ascertain that the world is fluid, meaning intermediate and open to multiple perspectives (Charmaz, 2014). It is closely aligned with social constructionism which is discussed further below.

The foundations of symbolic interactionism were laid in the 1920s by pragmatist George Herbert Mead. Mead's interactionist perspective argued that socialising processes are how humans understand collective social definitions. Symbolic interactionism has attracted some criticism for ignoring factors such as institutions, moral structure and class struggle on the objective restraints on social action (Annells, 1997). Symbolic interactionists assert that society, including the actions and

interactions of others in the political and historical past, lay foundations and set conditions on which actors act in the present. The stage is set, and this social reality is tough and resistant to change (Charmaz, 2014), though collective construction/reconstruction of meaning can shape society. This is pertinent to the subject of suicide and the issues highlighted in the previous chapter.

According to Mead, social interaction comprises of two levels; that of *non-symbolic and symbolic interaction*. Mead refers to the former as a ‘conversation of gestures’ whereby individuals directly respond to the stimulus of others’ gestures or actions. The second level, *symbolic interaction*, is the interpretation and subsequent act that follows based on ‘*the meaning yielded by the interpretation*’ (Blumer, 1969, p. 66). ‘The meaning of a thing grows out of the ways in which other persons act toward the person with regard to the thing’ (p.4). It is a product arising from the process of interaction between people. Therefore, symbolic interactionism sees ‘meaning as social products that are formed through the defining activities of people as they interact’ and, crucially, all of this occurs through ‘a process of interpretation’ (Blumer, 1969, p.5). The use of meaning involves an interpretative process. The person (actor) points out to himself the things that have meaning, which is an ‘internalised, social process in that the actor is interacting with himself’ (ibid). Interpretation becomes a matter of handling meaning and hence explains subjectivity and the emphasis for reflexivity throughout the research journey.

Interpretation is not an application of prior meaning. Meaning is not constructed intrinsically (as per a realist stance) but meaning arises in the process of interaction between people through symbols such as language and gestures (Blumer, 1969). Both action and interpretation are reciprocal. People react in relation to how they view the situation, and in turn their actions and those of others affect situations and may alter their interpretation of the current context, past understanding or what may come (Blumer, 1969). As a result of interpretation, the intention or purpose may be managed differently, and the response may be postponed or modified.

Symbolic interactionists aim to enter the world of the participants to see the situation as seen by the actor; the inquirer seeks to understand the symbolic significance of language/gestures and symbols in the actors he/she is studying. In other words, the inquirer aims to discover what actors see as their social reality. According to Bryman, ‘interaction entails a continuous process of mutual interpretation of the nature of situations and how we believe our actions to be received’ (Bryman, 1988, p.55). Blumer (1969, p.8) states, ‘social interaction is a process that *forms* human conduct instead of being merely a means or a setting for the expression or release of human conduct...human beings in interacting with one another have to take account of what each other is coding.’ Blumer continues: ‘Action is seen as conduct which is constructed by the actor instead of response elicited from preformed organisation on him’ (Blumer, 1969, p.65). This brings in the notion of the human-self in constructing his or her act. Blumer developed the concept of the social construction of self from a symbolic interactionist perspective, whereby the actor has agency and responds to the object.

Harre (1988) purports that the 'I' or self has three dimensions: self-1, space and time, self-2, the totality of attributes of a person including the persons belief about him or herself and self-3, the sort of person we are taken to be by others. For Harre the accumulation of these selves is derived from the powers or skills of a person engaging in joint action. Selfhood is achieved by *knowing* and *enacting* what is expected within that context as, according to Harre, to be a 'self' is not to be a certain kind of being but to be in possession of a certain kind of *theory*, reflecting the sharing of symbols inherent in symbolic interactionism. Therefore, the beliefs that are implicit in language about being a person give us our subjective experience of self-hood. This is subject to historicity and context as, for Harre, the beliefs that we acquire about personhood are determined by the language we are born into. Harre's argument rests on the premise that there exists an 'ethological repertoire of natural expressions' (1998, p.48). This ties with varying cross-cultural definitions of suicide as described by Douglas (1992) and is therefore not constant or fixed across society. Harre's view of possessing a certain language or theory of self allows for the potential for change depending on the relationship between self-1, 2 and 3 and what is co-created in joint action. Locating suicide within the context of language and relationships suggests a paradigmatic 'truth' different from the reductionist definition of suicide described in the powerful medical discourse. Harre's perspective echoes elements of symbolic interactionism contributing to the understanding of human interdependency and therefore emphasises the interrelatedness of human beings.

Constructivism or constructionism?

It is necessary to introduce social constructivism/constructionism at this juncture. References to the focus of nursing in chapter two and the associated stance of intersubjective discourses and co-construction of reality through interpretation deems this necessary. Symbolic interactionism as referred to above is concerned with interpretation and the symbolic meaning of reality as constructed in language and symbols.

The focus of social constructivism opposes empiricism, adopting the claim that social reality cannot be objectively observed. Moreover it is the collective generation of meaning considered to be constructed by intersubjective discourse and knowledge sharing influenced by context (Blaikie 2007; Crotty, 1998; Mills et al., 2006).

It is by examining this that we can understand the nature of social reality. Meaning giving is therefore found in the interactive processes that takes place between people and by individuals bestowing interpretation on their own actions and experiences and the actions of others (Burr, 1995). Utilising a social constructivist theory encourages a critical approach to everyday knowledge that is taken for granted. Given that an implicit tenant is the *contextual* construction of reality, historical and cultural aspects are acknowledged (Burr, 1995). From this stance, ideas and shared meaning are considered not to be innate as different cultures and communities are likely to have different constructions of reality. Therefore within a constructivist epistemology, Blaikie (2007, p.23) argues there are no

absolute truths. The seminal work of Berger and Luckmann, *The Social Construction of Reality* (1967), posits that reality is constructed intersubjectively. Their work is influenced by symbolic interactionist theory. The foundation of their argument is the acknowledgment of reality experienced as 'here and now.' They articulate that everyday life is experienced in relation to degrees of closeness and remoteness to spatial and temporal realities or *zones*, and with intersubjectively with others. Berger and Luckmann introduced the concept that reality is socially constructed, arguing that, over time, action behaviours and concepts become imbedded into society as they are acted out in roles. According to the authors, people are generally interested in the object relations of the *immediate zone* in which they operate or *urgency* of what is required here and now. Although there are links to ways of being and activity that may be far removed from the immediate zone, the reality lived is immediate and with it is the intersubjective world shared with others. According to the authors, the concept of intersubjective reality acknowledges multiple realities, but with this is also a common correspondence between meanings.

Constructivism and constructionism are used interchangeably throughout the research literature (Bryman, 2008; Burr, 1995) often with limited or contrasting distinction between the terms (see table 1 below). Guterman (2006) emphasises biological and cognitive processes to describe constructivism and refers to the domain of social interchange to differentiate constructionism. It is apparent that the interchangeability of terms represents evolving discourses. Charmaz (2008) acknowledges the evolvement of social constructionism and currents of this in constructivist grounded theory. She purports that, in constructivism, knowing and learning are embedded in social life (Charmaz, 2014). She specifically chooses the term 'constructivist' to acknowledge subjectivity and the co-construction of meaning within research (2014). It is this stance that I also adopt. Interpretivism requires subjectivity, hence constructivism is the term adopted for this research which is also in keeping with symbolic interactionist perspectives. Because of the conceptual and theoretical basis described (interpersonal relatedness of human beings in joint action), constructivist grounded theory was chosen as the appropriate methodology.

Table 1. An overview of ontological and epistemological differences in constructivist research methodology. Adapted from Annells (1996, p. 124)

Author	Glaser and Strauss (1967)	Strauss and Corbin (1990)	Charmaz (2000, 2014)
Paradigm	Post positivist	Constructivism	Constructivism
Ontology	Critical realist	Relativist	Relativist
Epistemology	Modified Objectivist	Subjectivist	Subjectivist
Strategy	Inductive	Inductive	Abductive
Aims	<i>Generate</i> an inductive Grounded Theory	<i>Develop</i> an inductive Grounded Theory	<i>Construct</i> an inductive Grounded Theory
Knowledge is	Discovered	Verified (within data)	Constructed and multiple voices acknowledged
Resulting in	Generated grounded hypothesis	Some degree of verifies hypothesis	Interpretive portrayal of the world studied
Underpinned by	Symbolic Interactionism	Continual permutations of action theory	Symbolic Interactionism

Methodology - Grounded Theory

Extensive critiques exist in academic texts regarding the development of grounded theory from its original incarnation and positivist leanings. Developed by Glaser and Strauss (1967), ‘The Discovery of Grounded Theory’ emerged from traditions of positivism and pragmatism. Glaser and Strauss are often referred to as first-generation grounded theorists actively influencing the ‘first moment’ or traditional period of qualitative research (Denzin and Lincoln, 1994)

The grounded theory perspective developed offered an alternative approach to the traditional hypothetico-deductive methods employed by qualitative research at the time. Grounded theory emerged aiming to develop explanatory theory about human behaviour through discovering knowledge in the data collected, thereby generating an inductive grounded theory from said data. Commensurate with positivist views, Glaser and Straus (1967) advocated that the researcher position was to enter the field of research with few preconceived ideas, therefore assuming an objective position to understand the social world entered. This was achieved by *bracketing*. The researcher was to *close off* and *set aside* former knowledge of the phenomena.

Denzin and Lincoln's (1994) historical account of the changes of grounded theory offer political and social context to the susceptibility of theory transformation. As interactive beings, constructing meaning and understanding through personal, social and cultural contexts contends that development and change is an inevitable outcome. An example of this was with the publication of Strauss and Corbin's 'Basics of Qualitative Research' (1990) over twenty years on from the original version and in an era where qualitative research and grounded theory were gaining recognition. This text departed from the stance of the traditional period to reflect research through a post-positivist lens towards a constructivist lens (Annells, 1996). The ontological position of the later version assumes that 'reality cannot actually be known, but is always interpreted' (Strauss and Corbin, 1990, p.22), as opposed to a reality being captured and discovered in the data, as the original version contends. Strauss and Corbin proffer that the researcher features in the data analysis in that the data is interpreted and therefore contains the perspective of the researcher and, thus, the construction will be open to revision (Annells, 1996). This subverts the leaning of the original objective epistemology and adopts a relativist ontology. Also, in contrast to the original text, they include personal professional experience and the analytic process as sources of theoretical sensitivity. In addition to open coding, axial and selective coding appears with a coding framework. The product with this approach is the development of an understanding of a phenomenon which informs action, rather than a generalisable prescription (Annells, 1996; Charmaz, 2008; Birks and Mills, 2015).

Later incarnations of grounded theory include publication of the seminal text by Charmaz (1995) and a commitment to the term *constructivist* grounded theory. Charmaz relays that her evolved version returns to the classic statements of the original text by Glaser and Strauss and modernises it through application of a 21st century lens (2008). The inductive focus has shifted to abductive to reflect contemporary thought. The constant comparative and open-ended approaches are maintained as well as the theoretical influence of symbolic interactionism. The use of memos reflects Strauss and Corbin's work. Where Glaser refuted the text of Strauss and Corbin for forcing data into frameworks (Glaser, 1992) and creating a fixed approach, Charmaz is clear that, instead of offering a sequential map, methodological guidelines emphasising the importance of flexibility should be provided and the researcher should be immersed and guided by the interpretations of their own work on an emotional as well as pragmatic level (Charmaz, 2006). This is reminiscent of Dewey's assertion that emotional and intellectual involvement play a part in constructing meaning (Dewey, 1937). Hence the researcher's role is integral to constructing theory, (Clarke, 2005, Charmaz, 2006, 2014) and cannot be divorced from the conversation in which he/she partakes, highlighting the complexity of social research and the recognition that the researcher brings both personal and professional knowledge to the process.

These are the core principles of constructivism as discussed above in the paradigm of inquiry. Methodologically, 'reality arises from the interactive process and its temporal, cultural and structural

contexts' (Charmaz, 2000, p.523). Table 2 summarises the development of grounded theory from 1967 to 2014.

Table 2. Presenting ontological and epistemological differences in research methodology

	Constructivism	Ontological properties	Epistemological properties	Interpretivism
Denzin and Lincoln, (2005)	Referred to as a paradigm of enquiry	Relativist	Subjectivist	
Gray	Referred to as a theoretical perspective		Subjectivism Constructivism Crotty (1998)	Interpretivism is a theoretical perspective
Bryman (2008)	Referred to as an ontological stance	Constructionism Referred to as constructionism in the first instance, interchangeable application with constructivism		Interpretivism is an epistemological orientation
Guterman (2009)	Referred to as an epistemological stance		Subjectivist devised of Constructivism – biological and cognitive processes Constructionism – Social interchange	
Charmaz (2014)			Constructivism honours subjectivity and the social construction of reality between people	

Whereas earlier versions of grounded theory utilise an inductive approach, constructivist grounded theory employs the interpretative approach of 'abduction' for theory construction; the aim is to understand social life in terms of the motives and understanding of the social actors (Blaikie, 2007; Charmaz, 2006). The starting point is that of the social world of the social actors, connecting with them and being part of the conversation. It relies on cyclical processes, data collection, testing and theorising (Blaikie, 2007). Main features are of an iterative nonlinear process and creation of uncertainty, which is implicit in the version of grounded theory averred by Charmaz (2014). It contrasts with the linear logic of inductive and deductive reasoning whereby the establishment of universal generalisations are created to be used as pattern explanations (Blaikie 2007). Importantly in abductive terms, theory generation is implicit to the process of research rather than construed before or after (Blaikie, 2007; Clarke, 2005). It allows for further data collection and theorising throughout a helical process. In the case of constructivist grounded theory, it is this that is the core aspect of research supporting construction of meaning throughout (Charmaz, 2008, 2014).

Why Grounded Theory?

Pragmatism and symbolic interactionism are core to grounded theory (Collins, 2010) thus aligning the core tenets of the research. The subject position of the actors, and the representation of symbolic interactionism, allow fluidity and understanding of actions and events as interpreted. The researcher is not divorced from the context but is considered part of it, and thus the connection between self and others is integral to the theory in the constructivist version adopted.

It is also a well-placed theory for nursing, as it is a vehicle to understand interhuman interaction. The position of social constructivism is one of a world jointly constructed through language and interpersonal interactions. Nursing is based in dialogic interaction *in* and *through* interpersonal relationships with the intention of connecting with another human. The intention to communicate and connect precedes action. The tenets of constructivist grounded theory are that the understanding of meaning is *co-constructed* between individuals engaging in conversational exchange. Meaning making is something that the researcher is implicitly engaged in throughout the dialogue. The process emphasis is on *action*, concurrent with a Professional Doctorate and development of theory as, for Hood (2007), theory development is the goal of grounded theory.

Barker reflects, ‘life is a journey.... the fluid nature of it, human behaviour, human actions and interactions – the whole chaotic order of it’ (Barker, 1996, p.46). This perspective relates that such phenomena are not amenable to a form of inquiry. The fluidity and organic nature of life assumes that the phenomena of interest cannot be rendered stationary. The version of grounded theory adopted in this research acknowledges the interpretation of meaning and therefore the fluidity of conversations within cultural contexts and time and place. In symbolic interactionist and social constructionist theory, fluidity is acknowledged along with the common correspondence of meaning entrenched through roles (Berger and Luckmann, 1967).

Given the focus of nursing and interpersonal connection, other research methodology with a phenomenological focus could have been used, such as interpretive phenomenological analysis (IPA). IPA is recognised as a particularly useful method for researching phenomena which is complex, ambiguous and emotionally laden (Smith, Flowers, and Larkin, 2009). Suicide undoubtedly fits with this description and there are some overarching themes. Although IPA acknowledges roots in symbolic interactionism (Denzin, 1995), its central focus is understanding the meaning of events and experiences for the participants concerned, with a personal perception or account of an event (Jones and Osbourne, 2007). The researcher attempts to get close to the person’s world and reflexivity is used. IPA draws heavily on phenomenology and recognises double hermeneutics; participants first try to make meaning of their world, second, the researcher tries to decode meaning, making sense of the participants meaning making (Smith and Osbourne 2008). In IPA, researchers are encouraged to take a neutral position in data collection to capture rich data from the interview. The interpretive nature of the research comes next with decoding (Larkin and Thompson, 2012), a

double hermeneutic, a two-stage process.

Conversely, social constructionism posits that reality is constructed between the social actors. The researcher and the research become part of the co-construction and the researcher is therefore a co-participant as opposed to a detached observer. The emphasis is on the co-construction of meaning and interpretation of this. This is in keeping with the researcher stance and constructivist grounded theory methodology used in this research

Researcher stance

The stance adopted in relation to the research is that of *insider-outsider* (Raheim et al., 2016). The dual position of *insider-outsider*, *participant-researcher* as described by Raheim et al. is necessary given the constant negotiation of position with the researched. Insider researchers use personal experience and knowledge to gain an understanding of the situation. I cannot unknow what I know through personal and professional experiences. Furthermore, I acknowledge my personal construct of suicide, and this will undoubtedly transmit during the interactive process, but more importantly it will change as I am part of the co-construction of the situation (interviews and focus groups). The researcher assumes the position of being part of the creation of material. In relation to the construction and interpretation of what is said, Charmaz offers, ‘we construct our grounded theories through our past and present involvements and interactions with people, perspectives and research practices’ (2014, p.17). The collection and interpretation of the data effectively renders the researcher part of the constructed grounded theory. Blaikie (2010) refers to the researcher as *co-participant* and learner as opposed to detached observer and expert (Blaikie, 2007). There is an appreciation of the preconceived knowledge and information obtained from the initial literature search to contextualise the research; however, the research is aimed at understanding what *is now*, referring to what has immediately gone and what is constructed in response to symbols and interpretations. Lincoln (1991) coins the phrase ‘passionate participant’ to describe the researcher’s position in this domain:

‘...actively engaged in facilitating the “multivoice” reconstruction of his or her own construction as well as those of all other participants. Change is facilitated as reconstructions are formed and individuals are stimulated to act on them’ (Guba and Lincoln, 1994, p.115).

I am a passionate coparticipant in one sense but, significantly, I am an *insider-outsider*. Just as the insider component acknowledges what I bring and what I know, the outsider component signifies what I do not know. I do not know what it is to be suicidal and on the edge of life. This places me momentarily back into the position of researcher.

Chapter summary

This chapter has presented the conceptual framework for this research, inclusive of theoretical underpinnings and positionality. Essential with the development of the conceptual framework is the alignment of the theoretical framework along with the researcher stance. Chapter one is

commensurate with the presentation of material in this chapter and with my personal philosophy. Discussion was afforded to symbolic interactionism and social constructionism, and how this related to the methodological approach of constructivist grounded theory. It is important to explicate the approach to grounded theory given the variations in interpretation since the seminal work of Glaser and Strauss in 1967.

Chapter Six

Research Considerations and Methods

The following chapter discusses several methods undertaken in the process of the research, commencing with ethical approval and considerations for undertaking research of a sensitive nature. Research methods are discussed along with how the data was analysed using methods from constructivist grounded theory. Examples are given at the end of the chapter and in the appendices to demonstrate analyses and development, consideration is also given to the trustworthiness of the research.

Ethical approval

Adhering to research ethics ensures that four main ethical principles underpin the research; these are: respect for autonomy, non-maleficence, beneficence and justice (Beauchamp and Childress, 2008). The Economic and Social Research Council (ESRC, 2017) add respect for individual rights, maintaining dignity and respect, operating with integrity and transparency when conducting research, and well-informed voluntary participation where possible. I have mindfully walked the path of ethics believing that the subject of suicide requires dignity and respect in the wider sense. The position of this research is that conversations with suicidal others and nurses are contextual and co-constructed and hold historical and cultural significance. Suicide is a word with historical and cultural significance, not only within the wider social realms of society but also as the very use of the term represents those who have died and holds memories for those who may choose to participate.

The ethics for this study was also underpinned by the British Educational Research Association (BERA) guidelines (2011) and approval was granted by Northumbria University Ethics Committee (see Appendix 1). Permission was also sought from the Chairman of Launchpad; a social enterprise run by and for service users in and around Newcastle-upon-Tyne. Launchpad are involved in and encourage collaborative health research. A meeting was held in person to gain permission from the Chair to access users of the service. I also attended Launchpad's quarterly meeting to meet with stakeholders and users of services to share information of the research proposal, encourage transparency and seek further advice and perspectives to support participant experience of the research.

Consent

Participation was voluntary and informed. Interested parties responded to an email sent via the Chair of Launchpad containing an invitation letter and an information form encouraging people to familiarise themselves with the material. This informed the consent process from the outset. Understandable written information and verbal follow up is a prerequisite to participant consent according to Bryman (2008). Those who expressed an interest in participating received a contact

telephone call from me. A meeting was arranged to follow up the written information with a verbal explanation and to answer any further questions. I stressed that it was important that individuals felt comfortable and fully informed after meeting me before obtaining informed consent. Students were contacted via the internal university email system. Safety and consent were offered individually or in a group. Individual preference was respected (examples of consent forms and information leaflets are available in Appendix 1).

Participants were informed that they could leave the process at any time without recourse or consequence, adhering to the promotion of participant autonomy and decision making regarding ongoing participation (Houghton et al., 2010). This was pertinent as the original information sent out suggested a timely commitment, and this had to be highlighted at the outset for ethical reasons (the potential for commitment over a period of time). The iterative nature of grounded theory was explained to participants and student nurses and revisited during member checking (see memo in Appendix 2(v)). It was necessary to prepare the participants to go with the research 'flow'. I expressed that the process was also a journey for me and suggested that we walk some of it together.

Acknowledging relationships

I teach within the mental health programme as a senior lecturer. This includes teaching students across other fields of nursing and, as such, I may have been known to students within the cohorts involved in this study. There was a risk that students may have felt obliged to participate. This was addressed by careful oral and written explanation that decisions of participation/non- participation would have no bearing on the student's programme of studies. There was a risk that participants felt under scrutiny regarding their knowledge base. It was stressed to students that the focus of study was their experiences and that correct and incorrect answers were not being sought.

In addition, I was mindful of my roles as nurse/lecturer and researcher and the potential symbolism encased in this such as experience, expectations, interpretations and occupation of role position as nurse/patient. I decided to be open from the outset, and to briefly let people know about my roles and background, the death of my brother, and my genuine interest in their experiences and their potential use for the education of future nurses. This decision is significant when considering the researcher-researched relationship. It was an attempt to shift asymmetry from 'inferior' and 'superior' knowledge position (Raheim et al., 2016). By doing so Raheim et al. suggest that this renders the researcher vulnerable. In my view, it was an honest and transparent exchange; the 'researched' were volunteering to share their own stories in depth, rendering themselves potentially vulnerable. The nature of the research and the researcher-participant position adopted validates sharing a brief insight into the rationale and motivation for the researched.

Data protection

In compliance with data protection, interviews were recorded with a dedicated digital voice recorder.

The files were immediately transferred into a password-protected computer and then into a password-protected memory stick. Any paper data (e.g. interview transcripts, consent forms) were stored in a locked cabinet and only my supervisors and I had access to these. All names were deleted from interview transcripts and quotes, consent forms with the participants' names were kept in a locked cabinet, and participants were identified only by an ID number or a pseudonym.

Trustworthiness, credibility and rigour

According to Guba and Lincoln (1989), credibility, transferability and dependability are the composite parts of establishing trustworthiness in qualitative enquiry, which in turn establishes rigour (Guba and Lincoln, 2000). Trustworthiness and confirmability can occur when it is established that the researcher has accounted for interpretations throughout the body of work. With this is a clear decision trail and an account of influences on decision making (Koch and Harrington, 1998). This is akin to an audit trail with linkages to various decisions (Koch, 2006).

Crotty (1998) and Ravitch and Riggan (2012) refer to the importance of congruence throughout research. This relates to the alignment of the conceptual and theoretical framework with researcher position and methods used. In addition, they stress the importance of showing how this has collectively influenced decision making throughout the process. The conceptual framework, theoretical framework and researcher position was presented in the previous chapter. These are referred to throughout the thesis to demonstrate how data were generated, interpreted, explored and evaluated and how theory was developed.

Methods for enhancing trustworthiness include member checking (Creswell, 2005, 2014; Charmaz, 2014; Guba and Lincoln, 1989). It allows the researcher to sense check to see if interpretations are representative of what was shared. This can be undertaken during the process of data collection or the researcher can return to the participants afterwards. Member checking took place during this study. Participants were returned to and opportunities occurred for additional feedback. Memos pertaining to member checking are available in Appendix (ii).

Reflexivity is considered essential to interpretivist research. Clarke refers to 'embodied knowers' (2005, p.21) to acknowledge the experience of the researcher in the co-construction of knowledge. Reflexivity must be undertaken to acknowledge the researcher's contribution to the process of knowledge production and all that he/she brings. This is considered a positive contribution in interpretive research (Charmaz, 2001, 2014) and creates transparency in decision making. Examples of reflexivity are peppered throughout the thesis. Chapter one and excerpts from my travel journal emphasise my position, offering clarity to the intertwined journey and one thread of reflexivity.

Research methods

Sampling strategies

Sampling in grounded theory research is aimed toward theory construction as opposed to population representativeness (Charmaz, 2006). Representative samples assume generalisability, which is not the logic of grounded theory, and moreover participants are selected in a meaningful way. Instead, a target sample population was initially identified to find potential participants who had experience of the phenomena under investigation (Starks and Trinidad, 2007; Corbin and Strauss, 2008). The target population were people who had thoughts of suicide or who had been suicidal and had received contact from nurses, or treatment in the community or in an in-patient hospital setting. Once the target population was identified, initial sampling could occur. According to Charmaz (2006, p.100) ‘the main purpose of initial sample is to provide a point of departure not of theoretical elaboration or refinement.’ Therefore, selection of the initial participant(s) is a crucial departure point, as it is a place on which to base further sampling decisions.

Selecting individuals that have knowledge and experience of the phenomena of interest is referred to as purposive sampling (Cresswell and Plano Clark, 2011). This technique identifies rich cases for the most effective use of limited resources (Patton, 2002). Resources are limited to one organisation due to ethical approval in this research. Launchpad is a membership organisation and recovery college in Newcastle-upon-Tyne with an established reputation for supporting past and present users of mental health services and ensuring that their voice is heard. It is run by users of mental health services, past and present. Members are active in the North East area and are involved in service reviews, local government and Trust developments. Launchpad staff acknowledge commitment to research and support coproduction, another ethical chiming point. Approaching Launchpad to access the target sample population and to carry out purposive sampling echoed the value base of the research and addressed the sampling needs of the research. It anticipated the diversity of experiences lived and addressed the premise that suicidal individuals are present in social communities and not restricted to mental health services in receipt of treatment. It was important to engage personally with the chair person to talk about the basis of the research. This was met with enthusiasm and support. The chair person offered to disseminate the ethically-approved information sheet and criteria about the research to over 300 members. I followed up engagement by attending a quarterly board meeting in September 2015 to allow any questions to be addressed and to seek further advice from potential participations/user representatives. For example, the appropriateness of focus groups/individual interviews/venue and anything else that may have supported volunteers throughout the process.

Invitations to participate – those who have been suicidal

From the initial email distribution sent out via Launchpad, seven people responded. The second

request for participation engendered interest from a further three people, one person dropped out. Nine people were interviewed in total.

Purposive sampling and theoretical sampling

The starting point was the selection of one participant from Launchpad who met the criteria. An analysis of the initial interview, as described above, provided a point of departure to base further sampling decisions. Appendix 2(v) captures reflexive notes from the initial interview, and emerging areas of interest that influenced further sampling decisions (theoretical sampling). This was twofold. Firstly, selection was on the basis that the person had an experience regarding their presentation of suicide (for example, as described in the reflexive extract, there was a hunch that a *significant encounter* was experienced). The conversation evolved to be significant in itself. Secondly, limited resources encouraged exploration of significant encounters across gender and age range. The inquiry of what was initially termed a *significant encounter* was followed and interview questions changed to explore the unfolding tentative categories.

Inclusion criteria

The target population were people who had thoughts of suicide or who had been suicidal and had received contact, or treatment in the community or in an in-patient hospital setting, regarding this. There was no limitation on time lapse regarding the last point of contact. This is because it was the interpersonal experience at the point of need that was important and the focus of inquiry. Basic information was collected during initial phonecalls regarding the characteristics of the participants including age range, gender and where the person has received contact and/or treatment. See table 3 below.

Table 3. Participant characteristics - inclusion criteria

Sample source - Launchpad			Place of contact and number of contacts			Contact	
Participant	Gender	Age Bracket	Inpatient care MH/ acute general	Community mental health services	Other	Nurse	Other professional
Shaun	Male	46-55	Both	More than once		Yes	HCT, police, GP
Bridgette	Female	26-35	Both	More than once		Yes	HCT, GP
Nikita	Female	36-45	Both	More than once		Yes	HCT, GP
Joan	Female	46-55	Both	More than once	Yes	Yes	HCT, GP
Lilly	Female	36-45	Both	More than once		Yes	HCT, police, GP
Patricia	Female	56-65	Both	More than once		Yes	HCT, GP
Vivien	Female	18-25	Acute general	Once		Yes	HCT, GP
Kim	Female	18-25	No	No		Yes	GP
David	Male	56-65	MH	No		Yes	HCT, GP

Key; MH = mental health HCT = Health Care Team, GP= General Practitioner

Invitations to participate – student nurses

First- and second-year student nurses were contacted via their university email account through the social administrative office. Interestingly, initial expressions of interest came from mental health students and one adult nurse. Further request for expression of interest was circulated via heads of department to encourage nurses from other fields to participate. There was an expression of interest from twenty students in total. Of these sixteen student nurses took part in three separate focus groups. Two adult nurses and fourteen mental health nurses took part. Three focus groups were conducted within university premises, digitally recorded and transcribed. The duration was between 60 and 90 minutes. Due to the greater number of students, students were assigned codes. Due to the variation in clinical placements, not all student nurses had experience of engaging with suicidal people.

Table 4. *Student nurse characteristics*

Sample source – Northumbria University – Newcastle				
Student nurse and field of nursing	Gender	Age bracket	Field of nursing	Year of study
Adult (A1)	Female	18-25	Adult	1
Adult (A2)	Female	18-25	Adult	2
Mental health (MH1)	Female	18-25	Mental health	1
MH 2	Female	26-35*	Mental health	1
MH 3	Female	18-25	Mental health	1
MH 4	Female	18-25	Mental health	2
MH 5	Female	18-25	Mental health	1
MH 6	Female	18-25	Mental health	1
MH 7	Male	26-35*	Mental health	2
MH 8	Female	18-25	Mental health	1
MH 9	Female	26-35*	Mental health	3
MH 10	Female	18-25	Mental health	3
MH 11	Female	18-25	Mental health	3
MH12	Female	18-25	Mental health	3
MH 13	Male	18-25	Mental health	3
MH 14	Female	18-25	Mental health	3

*denotes mature students

Confidentiality

To preserve confidentiality, names were changed. It does appear impersonal to present finding without a brief biography of the participants, especially given the sensitivity and focus of the research. This is purposeful, as the participants were from a specific organisation and revealing personal demographics could possibly jeopardise anonymity.

Interviews took place at either university premises, the participant's workplace or the recovery college, depending on the person's preference. Interviews were digitally recorded and transcribed. The duration of each interview was between 45 and 90 minutes.

Data collection methods

Data were collected via semi-structured interviews, focus groups and field notes from those who had been suicidal (n=9) and student nurses (n=16). Of those who had been suicidal, seven participants were female and two male, with ages ranging from twenties to sixties. Sixteen nursing students were interviewed across three years of a preregistration undergraduate nursing degree programme; of these, fourteen were female and two males.

Interviews

The subject matter of suicide is of course emotive and sharing stories through interview can be cathartic, hence the venue preference and the understanding that the interviewee could access support should they require it was of importance. In all instances there was a named support person available as identified by the person themselves (in the workplace and at the recovery college). A colleague was on standby when interviewed and focus groups were held at a university. Interviews are an appropriate method of data collection for the purposes of grounded theory (Charmaz, 2011; Birks and Mills, 2015). Semi-structured interviews were used with open questions. The questions were shared with the information leaflet to minimise any anxieties that the participants may have regarding the type of question asked. These were as follows:

- What does suicide mean to you?
- What are your greatest needs when you have reached that point?
- Describe how an interaction with a nurse/professional has impacted upon you when you have been feeling suicidal
- Is there anything that a nurse/professional said or did to encourage a connection with you?
- What was most helpful? What else?
- Was there anything that made you feel that you could share your suicidal thoughts with this person? What was that?
- What do you need from a nurse to feel able to open up and talk about feeling suicidal? How would they demonstrate this?
- What advice would you give to student nurses finding themselves in a situation with someone who is suicidal?
- Think back on our discussions and tell me what we can do help the education of student nurses with suicidal people
- Is there anything else that we should have talked about and have not?

The initial sample and questions were as iterated above and a point of departure. Participant experiences and concerns were explored to allow engagement with initial and focussed coding. Simultaneously, attention was given to possible emerging areas of theoretical interest and, in the

spirit of the iterative process of grounded theory, the semi-structured interviews evolved as the process developed. For example, an emerging area of theoretical interest was a *significant encounter*. I created a tentative category from this and conducted further interviews for theoretical sampling. Theoretical sampling with participants revealed that the significant encounter was either positive or negative and pivotal, hence the *pivotal encounter* was created.

The process of interviewing is not merely a process of retrieving stored information. Interview data are a social action rather than retrieved information according to Holsstein and Gubrium (2009). In relation to the construction and interpretation of what is said, I am reminded of Charmaz's account; 'we construct our grounded theories through our past and present involvements and interactions with people, perspectives and research practices' (2014, p.17). The collection and interpretation of the data effectively renders the researcher part of the constructed grounded theory. With this in mind, there was a need for continuous reflexivity throughout the process. Bowling (2002) also referred to the disadvantage of smaller sample numbers when using interviewing for data collection in relation to claiming representativeness. Numbers of participants were a result of generation of theory through theoretical sensitivity as opposed to an agreed number of participants at the outset. As Charmaz (2014) purports, greater or smaller numbers do not necessarily ascertain quality or adequate outcomes. Emergence in the data and following the logic of theoretical sampling is key to quality data and the iterative nature of grounded theory.

Focus Groups

Urquhart (2013) suggests that individual interviews and focus groups are a supported method of data collection in grounded theory. Focus groups were also used for member-checking purposes as tentative categories emerged (Charmaz, 2014). This process can be used as part theoretical sampling process and can offer further insight into category development. It was also important to check language as I was keen to ensure that the categories I was using reflected what participants were relaying and not a result of referring to a preconceived framework from my nursing background. Creswell (2005, 2014) refers to such methods as important for enhancing the trustworthiness of the data. Plans were conceived for focus groups considering member engagement, field notes and next steps.

Considering participant's - respect and wellbeing

The research involved speaking to people who had experienced suicidal thoughts and behaviours in the past and acknowledges that this is a sensitive and emotive area. The core tenets of the research are that it is values-based, borrowing from action research, and is: 'to do with the care and respect of others' (Mc Donnell and McNiff, 2016, p.24). Demonstrating non-maleficence and beneficence are key features of the NMC Code of Conduct (2015) of which, as a registered mental health nurse, I have a moral and ethical duty to abide. Many tick boxes are fulfilled throughout ethics procedures and the expectations listed; however, it is noted that ethics in practice is living, organic and

interrelated:

‘Demonstrating ethical conduct is not simply a tick box exercise or the application of guidelines to everyday practices. It is far more complex, because we are talking about real- life people who all hold different values and try to live them in practice in their own way’ (McDonnell and McNiff, 2016, p.51).

It is uncertain what will arise when embarking on research conversations, therefore ethics constitutes a part of being with others and the interrelationship of people in conversation. Having practiced in the nursing profession for over 20 years, I have developed sensitivity for noticing stress and discomfort and I sought to be respectful and responsive to this and the needs of others throughout the duration of the research.

Sensitivity and respect for potential vulnerability regarding the discussion of past experiences was upheld, and this included students who may have disclosed suicidal thoughts and feelings. Information was available regarding support throughout the research, including signposting. For students this included access to university wellbeing services and support from guidance tutors, both of which could be contacted if there were any concerns. Part of the consent process included the students agreeing to their guidance tutor being informed of their participation in the research from the outset for pastoral purposes. Information regarding additional support was made available, such as national support helplines. A named colleague was available during the interview times for students and could be contacted if the student needed to leave the focus group and seek immediate support. A similar arrangement was offered for participants who, in addition, were informed that partners, family members/friends were welcome to accompany them to the interviews to offer support if desired. It was therefore necessary to constantly consider environmental factors and allow choice in relation to the location of interviews. Focus groups for students took place at university. Individual participants were asked about a preferred place of meeting, and responses included Launchpad Hub, the workplace and university premises (See Appendix 1 for consent and information leaflets).

Interviews and focus groups were opened and closed sensitively to ensure that participants left feeling safe and unexposed. This was informed by personal, professional and coaching experience and updates in related suicide awareness and prevention training. None of the participants left interviews or focus groups before they ended, and the feedback received at the end of interviews and focus groups affirmed the approach taken (see memo dated June 10th 2016 in Appendix ii).

I included a checklist and asked the following of participants who came together from individual interviews into a group; (a) do you feel you have been treated with respect? (b) please comment on general comfort (c) what can I do differently to enhance your experience? (d) getting in touch, what works best for you? Similar methods are advocated in participatory research (McDonnell and McNiff, 2016).

Data Analysis

Initial coding

Notably, grounded theory methods have evolved over time, with variations occurring in coding techniques. For example, there are differences noted in Glaser and Strauss (1967), Glaser (1978), Strauss and Corbin (1990, 1998) and Charmaz (2014) (see table 3 below for a comparison). Kathy Charmaz's (2014) version of grounded theory was followed for this research, with the incorporation of tools from situational analysis (Clarke, 2003; 2005). Figure 3 p.62 illustrates the interrelationship between stages of data collection, analysis and development of a grounded theory.

Line-by-line coding was the first step in the analytic process, described by Glaser (1978) as naming each line of the written data. Charmaz (2006, 2014) refers to this as an initial coding technique. This approach to initial coding allowed the data to be separated and categories to emerge. Charmaz argues that coding line by line allows you to see patterns that may be otherwise undetected, as it allows for greater analysis of the observations and actions of everyday life. During this process researchers are heeded to remain open to an array of possibilities that may emerge from the data. The researcher works quickly through the transcripts in the initial coding phase using constant comparative analysis across data transcripts (Charmaz, 2014). Code words are used to reflect the actions or processes described in the data, referred to as '*gerunds*' or '*in vivo*' codes. This is in keeping with the stance of symbolic interactionism and the focus of grounded theory, that being to use words to reflect actions or processes. Glaser (1978) encourages the use of *gerunds* in substantive coding, and for ways of identifying processes (Birks and Mills, 2011). At times, codes were derived from the actual words of the participants, and this is termed *in vivo* coding and advocated in versions of grounded theory by Glaser and Charmaz (Glaser, 1978; Charmaz, 2006; 2014). This encourages researchers to *listen* to the data, and if one gets called back to an *in vivo* code it's likely to be pertinent. This was the case in a few instances such as when Paula mentioned being dealt with 'unceremoniously' and Bridgette's articulation of 'walking the navigation line'; a term that represented preservation of freedom and choice above further involuntary engagement with the health system. Although other participants did not use this specific term, it appeared to capture collective meaning or experiences noted through the constant comparison process (Charmaz, 2006). Their experience being the symbolic interplay of self with the nurse or health professional and it remained as a contextual action later in the analysis.

Following leads in the data from initial coding generated the development of focussed coding and eventual theoretical categories (Birks and Mills, 2011; Charmaz, 2006, 2014). Charmaz argues that this aspect of grounded theory 'contains correctives that reduce the likelihood that researchers merely superimpose their preconceived notions on the data' (2014, p.125).

Table 5. Coding categories in grounded theory as per author.

Birks and Mills (2015)	Initial coding	Intermediate Coding	Advanced coding
Glaser and Strauss (1967)	Coding and comparing incidents	Integrating categories and properties	Delimiting theory
Glaser (1978)	Open coding	Selective coding	Theoretical coding
Strauss and Corbin (1990, 1998)	Open coding	Axial coding	Selective coding
Charmaz, (2014)	Initial coding	Focussed coding	Theoretical coding

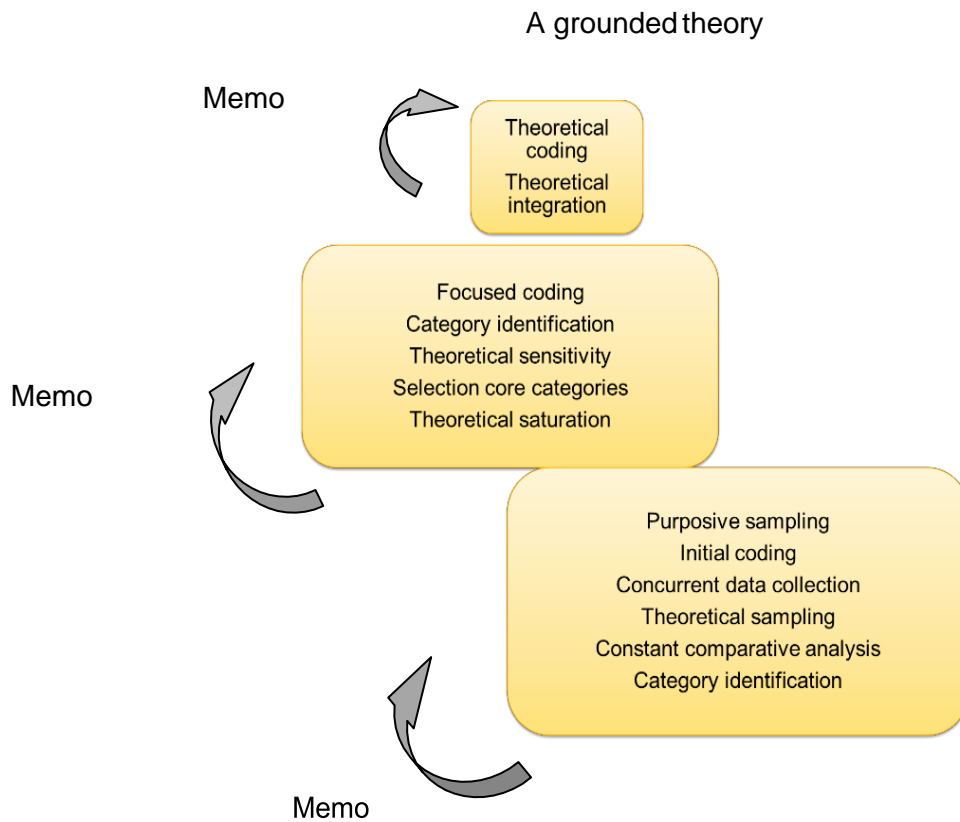
Focussed coding

Focussed coding follows on from initial coding. Focussed coding is created by reviewing initial codes and is used to explain large sections of data and direct analysis (Charmaz, 2014). It organises initial codes to a higher level of conceptualisation. The re-occurring codes were separated with those that were significant and meaningful offering a more directed, selected and conceptual approach (Glaser, 1978). It was important to interact and move through the data. This was a kinaesthetic process of engagement that I could not interact with via the computer screen. Initial codes were colour coded and printed from transcript data, linked and integrated as described above so I was able to identify the origins of the codes and source of data (see Appendix 2(i) for examples of initial codes and focussed codes).

Constant comparison and engagement with the data and focussed codes allowed for tentative categories to be developed. This was not a linear process, but rather an integrative process of constantly comparing and moving between the data representing a shared stance across participants. Birks and Mills describe the concurrent nature of data collection, analysis, coding and creating categories. This is summarised below (figure 3 p.62).

‘Concurrent data collection or generation and analysis using codes and categories is one of the essential methods that differentiated grounded theory from other qualitative research designs. From their time of their initial foray into the field, grounded theorists are analysing data. Constant comparison of incident with incident in the data leads to the generation of codes. Future incidents are then compared with existing codes, codes are compared with codes, groups of codes are collapsed into categories with which future codes are then compared, and categories are subsequently compared with categories, it is the constant comparison of the different conceptual level data analysis that drives theoretical sampling and the ongoing collection or generation of data’ (Birks and Mills, 2015, p.90).

Figure 3. Grounded theory methods employed in the research. Adapted from Birks and Mills (2015, p13)



Potential gaps in the tentative categories informed theoretical sampling, as well as going back to participants to check data and gather more data from new sources, such as year-three students in the development of student nurse data.

Category identification occurred with the collapsing of codes as I was able to identify patterns in the data. For example, I ended up with 15 categories. This was unwieldy, and I sensed that there was more merging to do. Constantly comparing categories and subcategories and questioning relationships between them allowed for further analysis and data generation. Grounded theorists offer differing methods for gaining details and developing theory about this process and exploring conceptual breadth and depth from these medium level concepts. For example, axial coding, as conceptualised by Strauss and Corbin (1990), is a way of relating categories and subcategories, which helps to specify the properties and dimensions of these categories and aims to assemble the data that has been fragmented back into an understandable whole. Strauss and Corbin refer to terms such as conditions, actions/interactions and consequences, referring to why, when, how and what, to look at the relationships within categories and subcategories. Though this gives a formal structure to the emerging analysis, Charmaz (2014) offers a less formal version and it was this that was utilised.

Axial coding was attempted but it appeared to push the data to the point where I was more concerned with working with the coding framework than the data. In keeping with the conceptual basis of constructivist grounded theory, I developed categories and subcategories, and show the links between them as they *emerged*, rather than applying a specific framework to the data as described above.

Theoretical sampling occurs when the researcher chooses who to talk to next based on the data analysis. This way the researcher follows what is in the data and any differences or gaps that may appear. Charmaz, (2006, p.96) defines this strategy as ‘seeking and collecting pertinent data to elaborate and refine categories in your emerging theory.’ The researcher collects and analyses data simultaneously to ensure the development of robust categories. It can involve interviewing additional participants, returning to previous participants or exploring reoccurring concepts, and involves supplementary strategies such as memo writing and use of diagrams to facilitate the process of building grounded theory (Charmaz, 2006, 2014). There are examples of memos and member checking in Appendix 2 (v).

Aiding abstraction - Theoretical memos and diagrams

The use of theoretical memos and diagrams can aid abstraction of the data and facilitate theoretical development. As referred to above, I found that I had too many categories and this needed to be refined in a way that would maintain the essence of the data and not lose it. Charmaz (2014) warns against the pitfalls during this process, as often researchers refer to disciplinary knowledge and integrate the language which deconstructs that of the participants. Checking that coding reflects the incident or described experience and noting clear connections between data and codes goes some way to mitigate against this. This was particularly challenging and took time to establish. During a conversation with a colleague it dawned on me that the reason I was ‘stuck’ was because I was afraid of refining the data further. I was worried that I would obscure the essence of the data and render participants’ voices mute. Once I understood my limitations I returned to the data. To aid with the development of theoretical abstraction I returned to the diagrammatical representations and reviewed the theoretical framework. There are various recognised ways to approach

Abstraction, including conditional matrix development (Strauss and Corbin, 1990) or the use of situational maps, as suggested by Clarke (2005). The memos and diagrams helped to generate theoretical sorting. From this I was able to see that there were specific areas where the data grouped together. This subsequently led to the collection of trajectories and the experience of suicide spatially and across time. As noted by Charmaz (2006, 2014) memo writing is fundamental in aiding methodological links to transform data into grounded theory. Memo writing offers insight and construction of grounded theory as the researcher constantly interacts with data. An example of this is given at the end of this chapter.

Theoretical sorting and coding

Refining, integrating and sorting theoretical memos and diagrams that have emerged through the process to this point is referred to as *theoretical sorting*. Sorting leads to *theoretical coding* and the development of grounded theory (Charmaz, 2014). Prescriptive coding frameworks exist to support this process (but according to Charmaz, can limit the creativity). Reference to extant literature can also be helpful but the researcher is warned of forcing data into extant theory (Charmaz, 2014) thus stifling originality of the research. The process, supported by Charmaz, is to remain open and reflexive to what is emerging within this process to support abstract theory development through becoming sensitive to the data.

Messy maps and theoretical abstraction

It is the processes of reflexivity, category refinement through mapping and constant comparison as an analytical method, that allows for *theoretical abstraction*. Employing further analytic strategies such as mapping assisted with this and allowed further development of theory and interconnectivity between categories. Creating messy maps described in situational analysis (Clarke, 2003) helped move the theory forward, support further category integration and advance coding. In keeping with Clarke's integration of categories, I was able to map links *between* categories as well as relations *within* categories and sub categories through integrating this with memos as described by Charmaz (2014) (see Appendix 2 [vi] for an example of the use of messy maps and the accompanying memo). The combined strategies (in-depth data analysis, return to the literature, comparison of data with data, code with code, category with category) as proposed by Charmaz (2006) supported the development of the grounded theory. The examples in Appendix 2(v) show the development of theoretical codes in conjunction with the comparison of diagrams and memos. Rather than aim for total theoretical saturation as originally developed by Glaser and Straus (1967), the final version presented in the findings chapter is representational of contemporary perspectives of grounded theory as proffered by Dey (1999) and Charmaz (2014); that is, theoretical abstraction was achieved and a grounded theory was developed representing the research findings which can be traced back through data sources. This is a transparent approach and account given the limitations in theoretical sampling which is discussed in the final chapter.

Chapter summary

This chapter contained a detailed presentation of the research methods applied. Data collection and analysis are discussed with examples of theory development as depicted in examples and reflexive memos. The journey is transparent and detailed following the tenets of a constructivist approach to grounded theory development. Examples of methods used throughout the grounded theory are available in the appendices to aid transparency of the process. Further consideration of transparency

and credibility regarding the production of the grounded theory in this research is discussed in chapter ten. Naturally, leading from this chapter (in chapter seven) are the findings and related discussion.

Part II Cycling

February 2004, Day 9 Jomson treck, Jomsom, Nepal

Spent some of today nattering with two Canadians in a café in Jomsom (psychiatrist and paediatrician). I think the psychiatrist was sent to challenge me. He was very respectful about RMN's saying that they really care about what they do, we're 'great' apparently. Stories and beliefs were exchanged but I could feel myself being wound up. They believed I was consumed and passionate about what I do, and this was 'a good thing' but they have no idea what I am feeling about it all and to be honest neither do I.... I think it might be more of a matter of being scared of going back to nursing.

'It's what keeps people stuck on that kind of wheel they don't really have those really uncomfortable conversations we avoid them, and for me they are the key conversations that are absolutely crucial at making a difference in somebodies' life.'

(Nikita, 58-59)

Chapter Seven

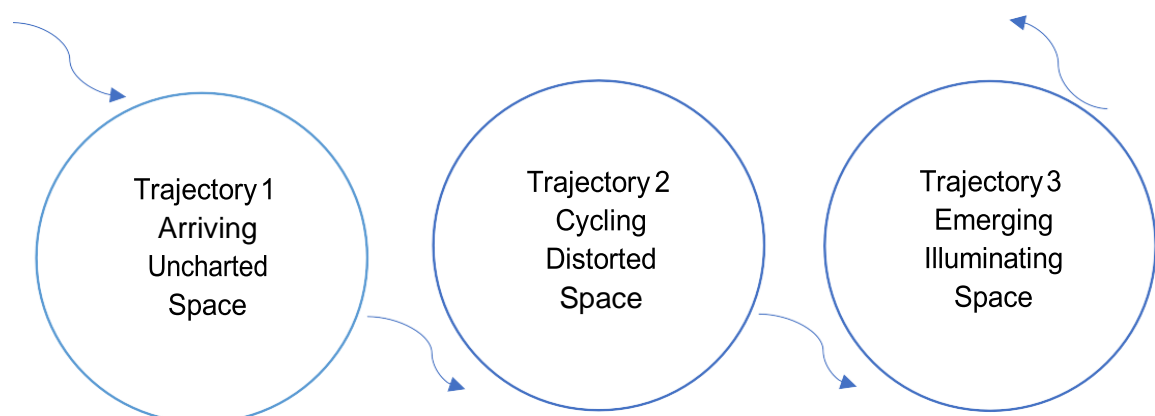
Findings and Discussion

The following chapter is a presentation and discussion of the findings. The core category is *Meeting Spaces*. The *unceremonious pivotal encounter* and *human pivotal encounter* are terms used to represent key areas of meeting in this space. The major categories are: *Arriving, lost in uncharted space*, *cycling in distorted space* and *Emerging in illuminating space* (for participants). Major categories for student nurses are similar (*Lost in translation - limiting spaces*, *Dissonance - distorted spaces* and *Emerging in illuminating spaces*). The major categories are presented in bold on the next page. The minor categories sit underneath with arrows pointing to the sub categories. There are notable similarities between participants and student nurses throughout the journey and these are discussed as and when appropriate throughout the chapter. All data can be traced back to the original interviews following the process of constructivist grounded theory as proposed by Charmaz (2014). The findings of the participants are presented first, followed by the from the student nurses. Students are referred to by their pseudonym findings and students by their codes.

Trajectories emerged as part of the theoretical coding and abstraction. The term trajectory is twofold in that it captures a course of development through the existential journey of suicide. The journey is viewed in three trajectories. *Trajectory I - Arriving: Lost in uncharted space*, *Trajectory II - Cycling in distorted space* and *Trajectory III - Emerging in illuminating space*. The term also links to space, which is in keeping with the theory developed and the core category of *Meeting Spaces*. Trajectories are synonymous with major categories.

Below is an outline of the trajectories across the suicidal journey. Each trajectory is discussed and detailed in the following chapter. A detailed overview of the journey is available in chapter nine, p.127 and Appendix 2(iii).

Figure 4. Outline of the suicidal journey.



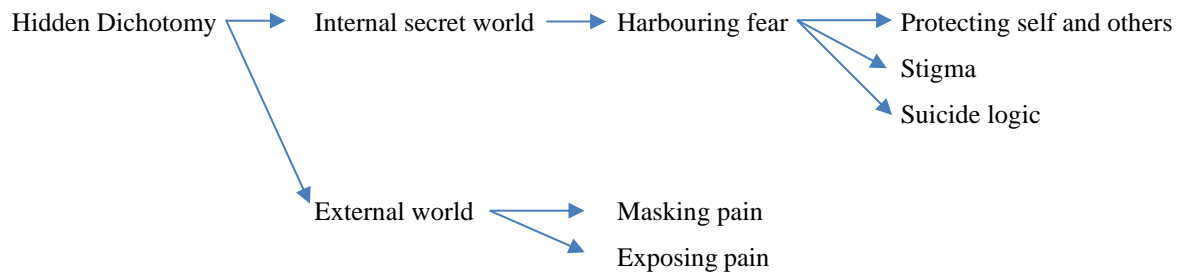
Findings and discussion – participants

Trajectory 1 - Major categories, minor categories and sub categories

(Major category) Arriving to suicide - Lost in uncharted space

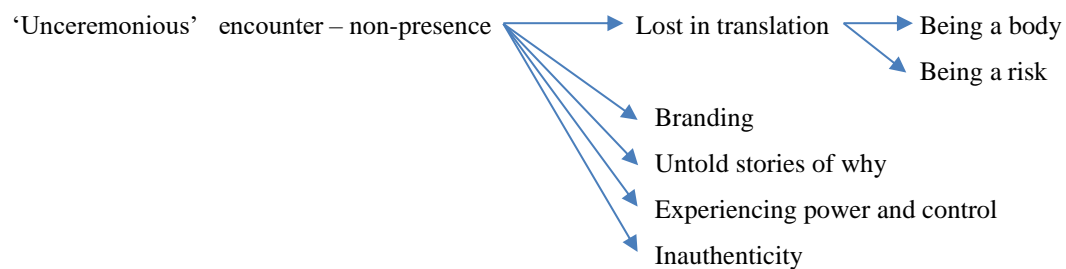
(Minor category) Harbours emotional pain → **Arriving to darkness (sub categories)**

→ Reaching an end
→ Navigating alone

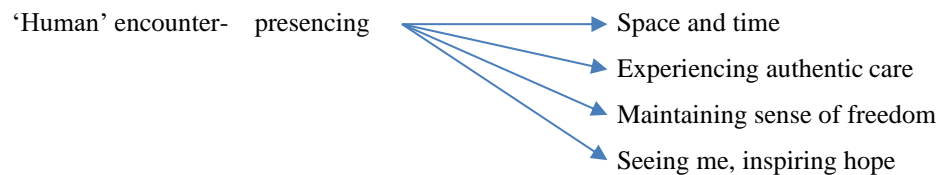


Trajectory 2 - Major categories, minor categories and sub categories

Pivotal encounter -Cycling in Distorted space (Contextual; walking the navigation line, invoking resistance. Result; needs thwarted)

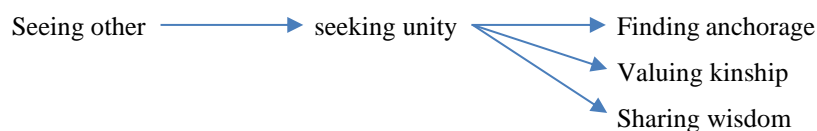


Pivotal encounter – Emerging in Illuminating space (Context; Walking the navigation line. Result; needs met)



Trajectory 3 - Major categories, minor categories and sub categories

Emerging, Illuminating space



Trajectory 1 - Arriving to suicide – lost in uncharted space

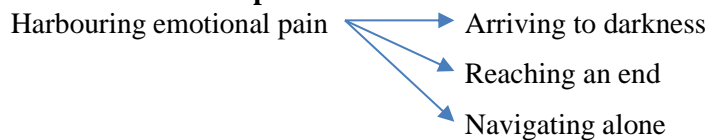
Figure 5. Outline of the journey -Trajectory 1



Arriving to suicide

Although I did not ask specifically about the start of their journey, all respondents took me through a passage with them, acknowledging a natural starting point. A key feature included arriving at suicide and what that was like. Some participants were able to articulate this whilst others struggled to find words. Participants were aware of personal emotional pain contributing to unrest. Whereas some described the onset of suicide as gradual, others described it as a surprise, the impact of which was akin to worldly forces of a tsunami; the water metaphor appeared again with the description of sinking. The term chosen for the category (uncharted space) captured the notion of uncharted places, traversing unmapped and unknown areas of self in relation to the experience of suicide. Trajectory 1 will be discussed in detail as depicted below.

Lost in uncharted space



Harbouring emotional pain is the minor category that relates to the sub categories of; *arriving to darkness*, *reaching and end* and *navigating alone*. Inherent in the stories shared by participations was the overriding emotional pain, a thread that was returned to throughout the interview and the deep desire to be free of the pain. Schneidman (1983) coined the term ‘psychache’ to explain the sense of overwhelming pain leading to suicide as a response. Each story of course is deeply personal and unique to the person and the time and place of recounting and reconstructing an event. The subcategories related to *arriving to darkness*, as in reaching an ending and navigating alone without any perceived choice.

The excerpts below demonstrate the power of arriving to suicide and the re-occurring themes of darkness:

‘...and I didn’t realise I had these issues at all, it suddenly just hit me like a giant tsunami of emotion and I couldn’t deal with it. I didn’t understand it, I just

knew I wanted to die' (Pauline, 106 -107).

'...it's about that sinking horrible feeling and that dark place of just nothingness really, so I think it was really weird to think that I would ever be in that position because beforehand, I would never have thought that I would' (Lillian, 6-8).

Both examples hold a surprise element of arriving at suicide. Shaun captured the power of darkness and loneliness when relaying what suicide meant to him:

'Suicide to me means that a person has reached a point in their life, a very dark place where they can't see a way out. They've probably got no support off anybody. They feel that they can't speak to anybody, they are at their wits end and the only way they can see out of the situation is by taking their own life' (Shaun, 7-8).

Shaun referred to the third person in his response, as if referring to another self. The perception of needing an ending to the pain featured across all participants. What was poignant was the shared view that, at the time of distress, there was no choice and suicide was the only option. This reflects Pridmore's view that suicide is ultimately an escape strategy from a trying situation which the individual finds it difficult to extricate themselves from (Pridmore, 2010). It is interesting to note that the distress of suicide was expressed as a powerful 'tsunami of emotion' to expressions of 'nothingness.' Therefore, distress, as described by participants, does not have to be obvious. It can be quiet and contemplative but no less powerful. Kim expressed the intersection of not wanting to live and not wanting to die, often termed and referred to as ambivalence throughout the literature: '...in that minute nothing literally nothing matters other than wanting to die but actually not wanting to die' (Kim, 228).

The participants wanted an ending to the emotional situation they encountered; and dying appeared to be the only choice at a given moment, ending pain. Participants described arriving at the point of suicide, often with no pre-warning and with a sense of suicide being the only answer. For Snyder, (1994) suicide is the final act of hope as it is the only option perceived to be open to the suicidal person. For participants, suicide was expressed as navigating to a literal end. Suicide is considered the last resort as it is the last option. It is not perceived to be an actual choice, as a choice signifies more than one option:

'There is no way out and feeling that's the best possible option at that time, there are no choices' (Vivienne, 6).

'It's like a big, strange place to be. It feels like there isn't any choices' (Joan, 14).

An important point noted was that, for some, it was not the actual pain encountered by a particular event that was causative of suicide; it was the feeling of aloneness in dealing with the pain/distress story that was overwhelming.

Navigating alone; the features of this subcategory demonstrated the crucial importance of intervening and asking about suicide. The participants described feeling alone, without any choice and with limited knowledge. Feeling alone and unable to share meant that participants decreased their options

in relation to seeing beyond suicidality. Participants offered naivety as one reason for their response to arriving at suicide; and this was expressed in terms of not understanding self, and a lack of personal strategies and ability to deal with given situations:

'I felt completely alone. I reached a point where I couldn't go on and I couldn't see any way out of the situation or where to turn to, so I swallowed some Valium tablets and just hoped that it would all go away' (Pauline, 38-31).

'...it wasn't so much what had happened it was the fact that I felt that I had no one to help me through what had happened, and I didn't know how to do it on my own' (Bridgette, 75-76).

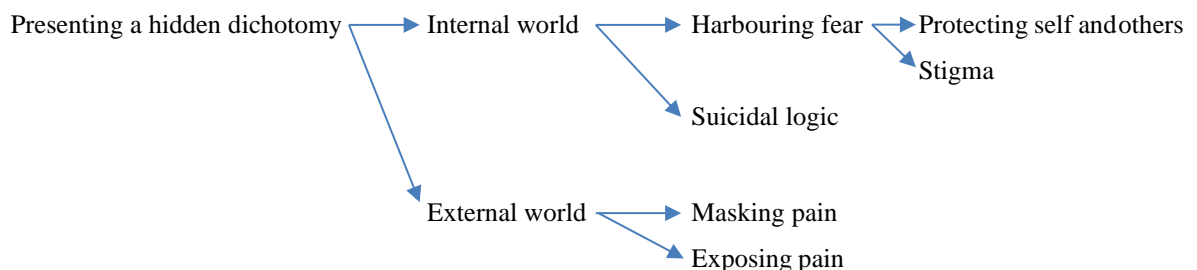
Naivety was a term used by Bridgette regarding taking an overdose and fits with the statement above:

'I just thought, I don't know how to deal with this, I don't have these strategies or whatever, so I took an overdose and I ended up having to go into hospital a physical hospital because I became really unwell. I was so naive to everything' (Bridgette, 40-41).

The *in vivo* term of naivety captured what participants were saying regarding the decision to attempt suicide and the choice of method. This is significant in relation to the interpretation of chosen method and the judgement of intent discussed earlier in chapter three p.20:

'I don't think I was scared of dying as such, or scared of how I would feel as I was progressing through you know, taking the tablets because I had never done it, so I didn't know whether I would be sick, whether I would be awake or how long it would take' (Lillian, 81-82).

The shared story of pain was the context of the arrival at uncharted ground, pulling the person away from the navigation point of the familiar self. Arriving to suicide, alone and in the dark without navigation aroused unbearable and unknown feelings, thrusting the individual into unknown territories of self. In symbolic interactionist terms, the person constructed meaning from their interaction with other individuals and society. The significance of being suicidal is that the person hid their suicidal thoughts, thus the opportunity to co-construct a different way of being was missed and the person constructs meaning from what is available. They became trapped in the story and the resolution of suicide. This is referred to as a psychological state of entrapment (O'Connor 2011; O'Connor and Portsky, 2018).



Presenting a hidden dichotomy is a minor category of *arriving to suicide, lost in uncharted space*. It captured the occupation of two worlds (*internal and external*). Throughout the process of feeling suicidal, participants described how they were being in relation to others around them. Through

continued interaction with the interview data, it became apparent that a conflict was experienced. The data demonstrated a division of what was occurring in the *internal 'secret' world*:

‘...it [suicide] was a secret’ (Vivienne, 80).

In the *internal world*, participants harboured fear. This fear preceded reluctance to share due to the unwanted consequences they may incur:

‘...for me, sectioning is a really massive barrier. I believe the fact that I knew that I could end up being locked up meant that I didn’t feel safe ever telling anyone how I felt’ (Bridgette, 79-8).

Unwanted consequences were related to institutional power and loss of freedom, which reoccurs in the next section. The extent of David’s fear was significant:

‘...medical people are to be afraid of because they can incarcerate you, give you drugs which they wouldn’t use themselves’ (David, 53 -54).

Protecting self and others. Fear of unwanted consequences extended to family, hence there was a deep sense of responsibility associated with hiding suicidality or, more significantly, the story associated with suicidality. Research by Owens et al. (2011) proposes that countersigns may be employed by suicidal persons as sparing others distress and keeping up appearances. In the following excerpt, Shaun highlighted the responsibility of protecting his family:

‘I wanted to tell my mam obviously, but I didn’t want to upset her because I have a younger sister ...I didn’t want to kind of split the family up as well and I wanted to tell my dad but I knew if I told my dad something like that he would have probably spent his life in prison because he probably would have murdered the bloke’ (Shaun, 25-28).

Whilst Pauline recalled the consequences of relaying her suicide story to a nurse:

‘...at the end of one particular session, and it had been a very emotive session, I came out of there and she just broke down. She broke down in front of me.....and I am thinking this poor woman, I can’t possibly come back here again’ (Pauline, 166 – 168).

Pauline was aware of the impact that her story had on another. This was highlighted throughout interviews with other participants. They relayed assessing whether it was safe to share with the helper. There was a continuous assessment of trust and the emotional ability of the others to hold the space. This is consistent with symbolic interactionist views; in that the participants were acting in view of their unfolding situations and in response to how this was viewed (Charmaz, 2014).

Stigma. The concern of *stigma* emerged as significant in the decision to share. Goffman defines the term stigma as: ‘an attribute that is deeply discrediting’ (1963, p.13). He further described three main types of stigma; first, tribal stigma of race, secondly, abominations of the body and, finally, blemishes of individual character, including weak will, being domineering or having unnatural passions, being treacherous and holding rigid beliefs and dishonesty (1963, p.14). It is the latter category to which Goffman attributes suicidal attempts and mental disorder. Stigma was experienced from friends,

family and strangers which compounded the fear of sharing thoughts about suicide. Stigma also related to hospitalisation because of suicidality and stigmatising attitudes from health care staff:

‘...it’s a scary concept you know, the stigma and the discrimination that is out there, that is attached to it [suicide] and then when your family and everybody is discriminating and stigmatising towards you as well, that just makes it worse’ (Lilly, 98-100).

Shaun experienced stigma in a situation whereby he was desperately communicating his pain, whilst fearful of the consequences of telling his father what the cause of his pain were. The irony here was that he was trying to protect his father:

‘... people in the bar would then sort of be very disrespectful to me because they were just calling me a nut case, and nobody wanted to say what’s wrong with you Shaun? It was always, ‘here is the nutter again’ and it got to the point where my dad actually walked out of the bar when I walked in and that to me was like more rejection’ (Shaun, 39-42).

This exemplifies Goffman’s point of an individual who may have otherwise been ordinarily accepted in social situations but is excluded due to the possession of a particular trait, rendering other attributes associated with that person insufficient. The stigma is ‘an undesired differentness’ from what is socially anticipated (1963, p.15).

Suicide logic appeared throughout the interview data, with all participants describing a rationale or logic to why they should not be in the world. At this point, the person was unable to appreciate their value to others and the impact of their death on those w hom they knew and loved. All participants bar one offered such an outlook regarding the logic of their decisions. This was, that family would be better off without them and that suicide, at the time of harbouring emotional pain and distress, is a selfless act rather than a selfish act:

‘...people think that suicide is a selfish option and I don’t think it is. I think people do it as kind of a selfless act thinking that their family and friends would be better off, that would be the best way when actually, it’s not when you are an outsider’ (Vivienne, 10-11).

The pain would stop for the person in distress, therefore the pain they projected onto loved ones would also diminish and, in time, normality would resume. Joan shared a vivid picture in relation to this point:

‘...at that time, it’s just so dark and you think that the world is a much better place without you in it, so people would say to me, nurses, psychologist, psychiatrists, how can you contemplate ending your life when you have got a loving husband and two beautiful children? That didn’t mean anything to me because in my head I was damaging the children and my husband loved me unconditionally, but I didn’t notice that at the time. I thought he would be much better off going and finding somebody who was whole instead of this damaged person’ (Joan, 20-23).

This is consistent with Joiner’s interpersonal theory of suicide (Joiner, 2005). Joiner proffers that thwarted belonging and perceived burdensomeness are key features of suicidality and it is likely that

the individual will feel one or both. Joiner concludes that perceived burdensomeness is ‘the idea that one is defective or flawed such that not only one’s self is brought down but, even worse, one’s existence burdens family, friends and society’ (2009, p.6). What was evident across interviews was the sense of disconnectedness from significant others, as if watching oneself in a film role. This element of disconnectedness is not surprising given the poignant descriptions of arriving to uncharted ground and traversing the edges of self. Participants inhabited a different space and synonymous with this was interhuman disconnectedness. Klonsky and May (2015) relay in their three-step theory model of suicide that pain, hopelessness and disrupted connectedness collectively bring about suicidal ideation. This chimes with Durkheim’s egoistic suicide, and the person’s lack of integration and subsequent detachment from social groups (Durkheim, 1952).

Presenting a hidden dichotomy captures the *internal world* as presented above and the *external world* which will now be discussed. The participants described wearing a mask (*masking pain* to the *external world*). The metaphor is fitting as it suggested that the person is partially hidden. The person may give out messages, but often these are not noticed or are interpreted as a joke. Messages may be in the form of letters, hints, buying tablets in presence of others, text messages, visits to the doctor, and unresolved concerns. They may be very vague. There is a sense that the strength of feeling and distress internalised is somehow tangible to the outside; it is loud and leaking through. *Masking pain* was a significant feature across participants for the reasons described; participants spoke about wearing a mask and hiding internal feelings to the external world:

‘...it’s kind of like paralyses....and it’s like a huge mask that you have on. You are screaming on the inside’ (Kim, 212).

‘I am quite a bubbly person and I don’t think anyone saw that there was problem where actually I was just kind of masked. I was putting it on to pretend I was happy’ (Vivienne, 88-89).

This is also indicative of establishing countersigns as described above by Owens et al. (2011). The following excerpt from Lillian’s interview demonstrates traversing both the internal and external worlds:

‘...it is very surreal for me because I used to overdose and end up in A & E, stay overnight, be treated go home and go to work the next day because it was made out that you know, just get on with your life and just do things and everything will be fine and this is selfish and so, I would just go back to work, and I would be sitting at work or standing at work thinking this is so bizarre because nothing had changed in me but I was having to act like it had and that was the hardest thing’ (Lillian, 56-60).

The dichotomy for Lillian is evident in that she was expressing her pain, though nothing had changed to allow the pain to subside; hence, the mask was redonned and Lillian inhabited a cyclical world of hiding and exposing pain. Vivienne gave insight into the subtle clues of sharing to the outside world:

‘I set a time when I kind of knew what would be the best time so I took the paracetamols and I text some close friends, it wasn’t like a message to say... it was just a message to say that I loved them and I tried to do it in a way that

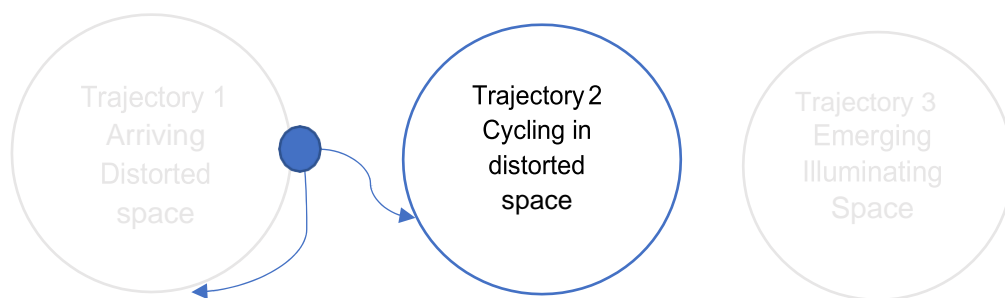
didn't really sound like I was trying to kill myself but it must have done because one of my friends rang my parent's home and they rushed me to the hospital and I stayed in there for about four days' (Vivienne, 94-97).

Such messages were not uncommon, though some were more overt than others. The participants silenced in words were screaming out their pain via their expressed action, though often unseen or misinterpreted by those close by often due to the ambiguity of the presentation. Owens et al. (2011) specifically identify proximity and emotional investment of families as difficulties in seeing what is unfolding with the suicidal person. These factors also make it difficult for family members to say anything to the person or to others in the social network. Additionally, warning signs were considered 'vague.'

Trajectory 2 – *cycling in distorted space* follows Trajectory 1. These are linked by a pivotal encounter. These will be discussed in turn.

Trajectory 2 - Cycling in Disorted Space

Figure 6. Outline of the journey -Trajectory 2

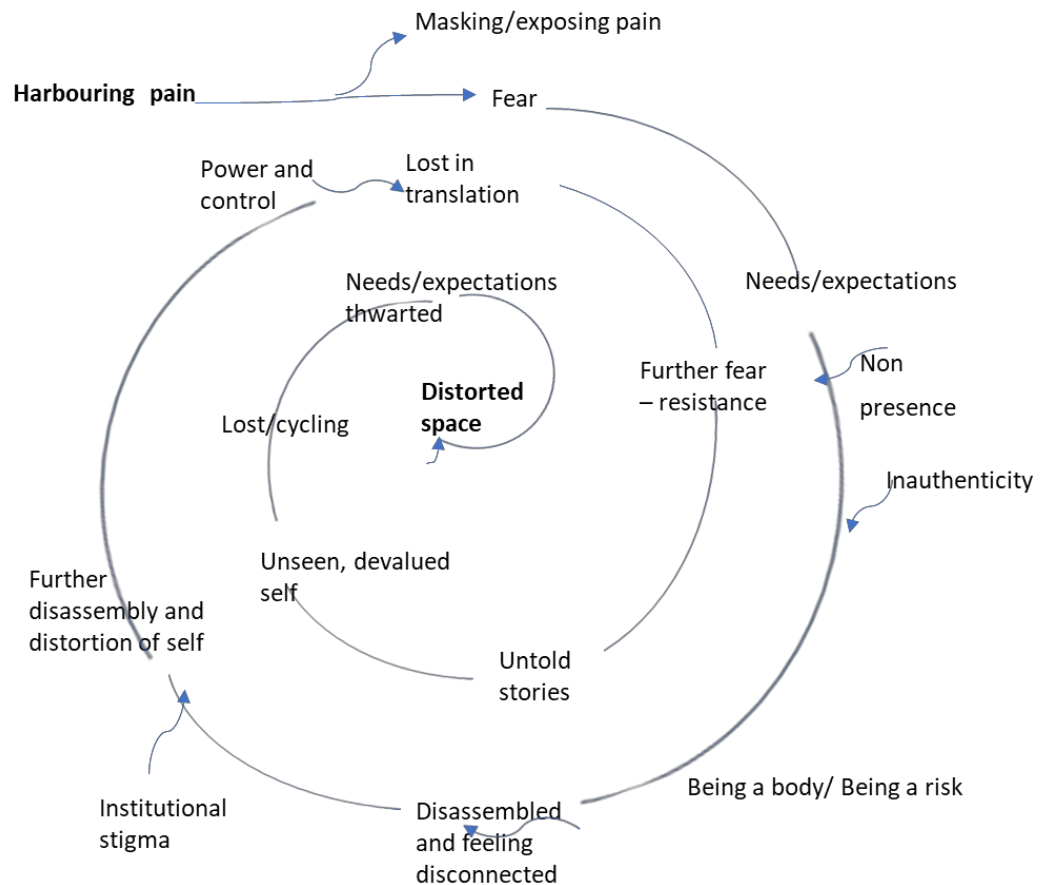


Unceremonious pivotal encounter

The bridge between each trajectory is termed the pivotal encounter. This is illustrated above by a blue circle and can be seen in detail in the figure. The pivotal encounter was a space where a specific type of dialogue and exchange took place (what the person choose to share, how trustworthy the helper was, and how they understand how they were being translated). It is where the person made sense of being suicidal. For example, the nurse translated this through personal, socio-political, cultural, institutional and professional lenses. Participants relayed that this was incomprehensible to them and it was like 'communicating in riddles.' It was incompatible with the needs and situation. Participants experienced a new language exchange that was shocking and incomprehensible. In symbolic interactionism, a focus on interaction is crucial as 'interpretation and action rise from the interaction, whether we address the reconstructed past, lived present or imagined future' (Charmaz, 2014, p.265). It was apparent from the data that the meeting of suicidal person and nurse created a pivotal encounter which was either an '*unceremonious encounter*' creating *distorted space*, or conversely, a *human encounter* creating *illuminating space*. The terms were taken from in vivo coding. The pivotal encounter helps understand one of the key questions of this thesis. What is needed by the suicidal

person to engage in conversations about suicide? What is needed is also understood by what is not needed or desired. The unceremonious pivotal encounter is aligned with distorted space and is discussed first. The unceremonious pivotal encounter is depicted below in figure 7. This is represented by the blue circle in the sequence above (figure 6).

Figure 7. *Unceremonious pivotal encounter*

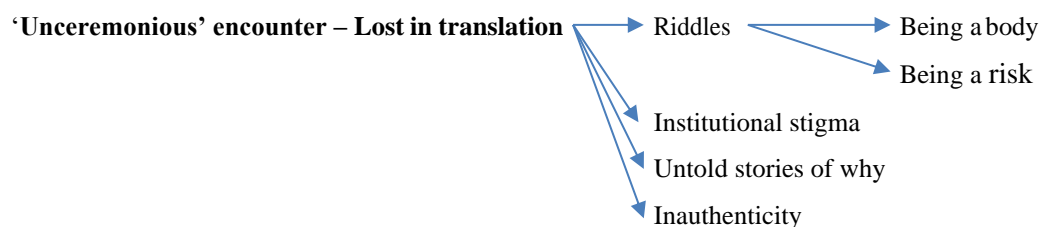


The unceremonious pivotal encounter and the inability to ‘get off the wheel’ appeared to create a cycling motion; stories were untold and needs unmet. The person had not collected enough anchorage to see another way through the harbouring of pain. Through constant comparison of the data, cycling became a key feature of the movement of participants until their story was told or somehow resolved:

‘What keeps people stuck on that kind of wheel, they don’t really have those really uncomfortable conversations. We avoid them and for me they are the key conversations that are absolutely crucial at making a difference in somebodies’ life’ (Nikita, 58-59).

‘It was just like going around and round in a circle and I couldn’t see any way out’ (Lillian, 18-19).

Distorted space (Contextual; walking the navigation line. Result; needs thwarted, invoking resistance)



The pivotal encounter represented the site of action between the helper and the person in distress. Interactions in an *unceremonial encounter* created distorted space. This was a complex site of interaction. Consistent across interviews were contextual factors, such as the fear discussed above and specific needs such as the need to be relieved of the emotional pain of suicide. As this category represents *unceremonial encounters*, pain is harboured and the opportunity to share passes, hence the participants are left with unshared emotions. The in vivo term of unceremonial was chosen as it captured the essence of others’ experiences. It also speaks of the expected ceremonial nature of receiving care, including the trajectory into a care pathway, the reception of the person, assessment and exploration of the presentation. The unceremonial encounter is devoid of delivering such expectation of value and care. Although not directly spoken, there was an inherent expectation at the point of reception regarding the helper. Nurses symbolised care and humanness, and some participants expressed shock when encounters did not meet this, thereby contributing towards further disassembly and distortion of self in a world that is already unrecognisable and new. Fried (1981) refers to this as fidelity, as there is a symbolic expectation and representation of nurses and when this is not honoured, there is no fidelity between reality and expectation, which is historically and contextually bound. Expectations and experiences were misaligned, consistent with findings reported in Dunkley et al. (2017). Bridgette articulated the inherent expectation of a kind response to distress:

‘...I don’t view my experiences as medical. I view them as very human

experiences, to me it is not someone else's job to be human and to be compassionate.... I don't think it is a job to be kind. I think that should just be a human response' (Bridgette, 277 -279).

Depending on circumstance, the person moved further into uncharted ground, from the edges of the map of self to unmapped areas of services where a different set of socio-political/medico- legal languages operate. Subjected to translation and *communicating in riddles*, crucially, the participants' personal experience of suicide did not match that what was reflected to them. Lost in translation defined the category as it represented the discursive nature of how participants were defined, negotiating language and unclear messages.

On being a body Bridgette explained:

'when all these things were happening, everyone focused on my physical health because it's always been like, that's what we have to fix now and there were times when I have been crying and like you are fixing the wrong bit, like it's up here. It doesn't matter if you sort all this out if I don't get this bit sorted it doesn't matter' (Bridgette, 262-264).

Bridgette talked about the shear agony of being focused upon as a body, as at that time the professional would have been focussed on preserving her life. Though for Bridgette, she saw this as incomprehensible as her needs were located elsewhere. None of the interventions mattered to her, and the body may as well have died if her suicidal pain was not helped. The immediacy and centrality of her needs differed from the priorities of the professionals, particularly their lack of acknowledgment of fixing the 'whole' person was significant. The manifestation of suicide was located in the body for the professionals and was the key focus, though for Bridgette her emotional distress was located within her body and between relationships, fusing emotional pain and physical pain as one. Schneidman offers; 'The most important question to a potentially suicidal person is not an inquiry about family history or laboratory tests of blood or spinal fluid, but 'where do you hurt' and 'how can I help you?'' (1996, p.6).

Schneidman's response focuses upon the psychological experience of the distress as opposed to locating it into a biomedical paradigm which further alienates the recipient, although it purports that the helper has privileged knowledge to allow the helping to occur. For nursing and a symbolic interactionist approach, the focus is encouraging the conditions to ask about suicide and allow the *story of why* to be shared. How the story is held and encouraged to emerge during the interaction is in itself the helping encounter.

Consistent with lost in translation was the focus of nurses and professionals on risk assessment. On *being a risk*, there was a shared perception of the limitations of risk assessment and the confinements of it. The experience and the language to assess risk via application of medically-constructed language and concepts created further distortion of self. Lillian demonstrated the lack of representation of her suicide attempt:

‘It’s how they write it rather than how they view it because they have to write it very differently. It’s like on your FACE risk assessment, it will say, are you at risk of death by suicide? And they will go, no, accidental death, well it’s not accidental if you have tried to kill yourself is it?’ (Lillian, 378-380).

Lillian stated differences in experiences and explained her own actions, and those of the nurses responding to risk assessments:

‘...they [nurses] will say [the suicide attempt] it’s deliberate self-harm which yeah, it is deliberate self-harm but to me, I would make it very clear that if I was self-harming by cutting and I hadn’t gone into a vein or an artery or whatever then that was just self-harm and that’s fine, but suicide attempts for me, overdosing, were more than that’ (Lillian, 385 – 388).

Barker emphasises that unfortunately the term deliberate self-harm is still used, which carries moral judgement, as if an act is not deliberate then it is accidental, one can only harm oneself accidentally or intentionally, and hence deliberate self-harm becomes redundant (2004, p.180). A sense of frustration was shared amongst participants and their perception of not being heard or seen. This added to a sense of not being believed or taken seriously when the depth of personal despair was severe enough to overdose. Shaun’s views in a follow up session captured this beautifully, as he exclaimed, ‘do not judge the depth of my pain by the depth of my wounds.’ The action meant different things to the participant, as self-harming through cutting denoted something different emotionally than overdosing, but again this was lost in translation as the body was subjected to territorialisation. The comments below emphasise the difference in focus and the need to explain what suicide means in the persons’ own language:

‘It can be so many different things that they might be wanting to talk about, like they might be trying to tick the box of ‘have you had any thoughts of suicide?’ But actually, I might want to talk about how much I am struggling right now. They just want to get straight to the point, but actually if they just took the time to listen they would get their answer. If they were worth their salt, they would be able to find out if I was feeling suicidal by just listening to what I am saying’ (Bridgette, 202-205).

Barker (2004) calls for nurses to be aware of their impatience to intervene and asks that ample time is given for patients to respond. Fowler (2013) highlights the eagerness of clinicians to quickly adopt security interventions through referring quickly and directly to risk management strategies. Joan further emphasised the importance of finding meaning in the risk assessment, exploring deeper instead of assuming what may be positive in someone’s life:

‘It needs to be done in the right way to make you feel, well, valued.... rather than just, well, I will fill in a risk form, I have just got to tick this box’ (Joan, 301-304).

Joan offered further insight into being distorted by process and the assumptions of others in the process of risk assessment:

‘People make massive assumptions wrongly because they don’t understand what we mean by protective factors because people don’t have those really difficult conversations with you’ (Joan, 32-33).

Accurately assessing for suicide is a complex task bound up by experiences and values of those undertaking risk assessment. Assessment is also reliant upon the information available from the person in order to assess the risk (Cutcliffe and Barker, 2004). As indicated in the data, participants ‘*walking the navigation line*’ were continuously assessing what information to divulge and to what degree. Therefore, the information available can be sparse and is representative of memory, personal interpretation and the ability for the person to communicate their distress at the point of encountering an other. Cutcliffe and Barker (2004) stress that suicide is multifactorial in nature. A systematic review of the literature of self-harm and attempted suicide within in-patient services revealed a complex interplay of perception and emotional impact on nurses and patients (James et al., 2012). Despite this and the factors above, clinicians are expected to complete risk assessments and remain accountable for their decisions. Decades of research into predicting risk demonstrates that it is rarely predicted greater than a rate of chance (Quinliven et al., 2017) and national guidance (NICE, 2011) instructs against the use of risk assessment tools to predict suicide. In a literature review regarding decision making and suicide, Barlow (2016) highlighted the need for nurses to be prepared in clinical decision making around suicide, specifically identifying subjective risk cues and utilising therapeutic skills to gain the best assessment as opposed to reliance and focus upon risk assessment alone. A shift in focus therefore will construct meaningful interaction. Nikita offered the following insight:

‘All people want to do, professionals, family whatever, is stop you from doing the act without understanding. They don’t ask you why you feel like that what is going on inside your head?’ (Nikita, 33-34).

Participants relayed that their presentation was further distorted by *institutional stigma* by the care giver, resulting in them feeling dismissed and unseen. Findings from Smith et al. (2015) refer to such dysregulated responses impairing adaptive responses to distress containment and appropriate planning:

‘One of the nurses turned around and said, you know we have ill people in here to treat you are wasting our time’ (Shaun, 147- 148).

Vivienne referred to stigma by stating:

‘...they forwarded on my details to my local doctor and my doctor basically told me, I don’t know what you have got to be depressed about you have got a job, and you’ve got somewhere to live and just prescribed me anti-depressants and that was basically that’ (Vivienne, 99- 101).

Bridgette was on the receiving end of this viewpoint:

‘I think that it is so often seen as an illness and I don’t agree with that. I actually had a mental health professional tell me that anyone who attempts suicide or kills themselves is psychotic, because no one in their right mind would choose to end their life’ (Bridgette, 100-102).

Participants were left with emotional pain during unceremonial encounters, and these *untold stories of why* featured matter-of-fact interactions without the opportunity to share a story, to release the contained ‘secret’ of the internal world:

‘Nobody actually said to me why are you doing this? I think if some professional person had of said that to me then it might have made things different’ (Shaun, 20-21).

‘I felt that it was the bit in the middle that was missing. You kind of want someone to sit down and say, ‘how do you feel?’ and ‘why do you feel like that?’ (Kim, 256-257).

The notion of being left with ‘why’ was a shared feature across all participants and appeared to sustain a cycling motion.. Participants desperately needed to share why they were feeling suicidal and, through the experience of the conversations they were having, retreated further into self as the connection with other was not apparent. This effected a cycling journey, remaining with pain and disorientation by feeling unable to share the distress. Joan reflected upon the frustration of not being asked key questions:

‘Those key questions that have never been asked of me in years and yearsthose tricky questions around, not just, ‘have you got plans, have you got thoughts of suicide?’ It’s like an algorithm, tick bloody box’ (Joan, 49-51).

Left with ‘why’ increased feelings of negativity and, as a result, no hope was installed. Participants needed an opportunity to share the distress story, and the reaction of the other shaped and helped form the retelling of the story. For Liebrich (1999) the telling of the personal story is restorative and a ‘precious gift... the act of telling stories can restore people’ (p.5). Participants were clear about the impact of inauthenticity on their ability and willingness to share their story. This was constantly observed and negotiated (walking the navigation line). Lillian remarked:

‘I know when I walk into a ward or if I see staff I know the ones that are there because they genuinely care and the one that are there just to pick up a pay cheque at the end of the day and I can pick it out immediately’ (Lillian, 236 - 239).

Through observing staff, Lillian was able to decipher who she would choose to talk to. Ironically, Lillian demonstrated that she was also on the receiving end of this scrutiny. Unfortunately, like other participants, Lillian is judged by the information held about her, and what the nurse brought impacted upon the pivotal encounter:

‘She obviously had a perception of what I was like before she sat down in that chair’ (Lillian, 262).

Walking the navigation line

‘They are playing a game. They are playing at not playing a game. If I show them I see they are, I shall break the rules and they will punish me. I must play their game, of not seeing I see the game’ (Laing, 1970, p.82).

Walking the navigation line was initially thought as a separate action linked to *unceremonious encounters*, but it became apparent after constant comparison of the data that this was also pertinent to *human pivotal encounters*. When participants experienced meaningful interactions, an awareness of needing to *walk the navigation line* was present, showing an awareness of the power that divided

themselves as help-seeker and the person providing the response. David held a strong view that:

‘...it’s all about control, making people easy to control and manage because they are scared of what might happen if people become uncontrollable in their eyes’ (David, 63-64).

Aware of potentially unwanted consequences, Nikita relayed a method of invoking resistance:

‘You learn very quickly to curtail what you disclose because of what then might be the next course of action... I think you become very skilled at saying what they want to hear’ (Nikita, 92,102).

Walking the navigation line was consistent with Blumer’s explanation that social interaction forms human conduct:

‘Human beings in interacting with one another have to take account of what each other is coding...in the face of actions of others one may abandon an intention or purpose, revise it, check it or suspend end it, intensify or replace it’ (Blumer, 1969, p.8).

Vivienne’s comments demonstrated the dissolution of the navigation line in a human encounter only for it to re-emerge at the point where she realised that there may be consequences to sharing, despite feeling that she could open up only moments before:

‘...they treated me like an individual, like I was their kind of friend and that made me open up more to them and I could say anything but then we were at that point of, what if I say the wrong thing then I could get sectioned?’ (Vivienne, 134-135).

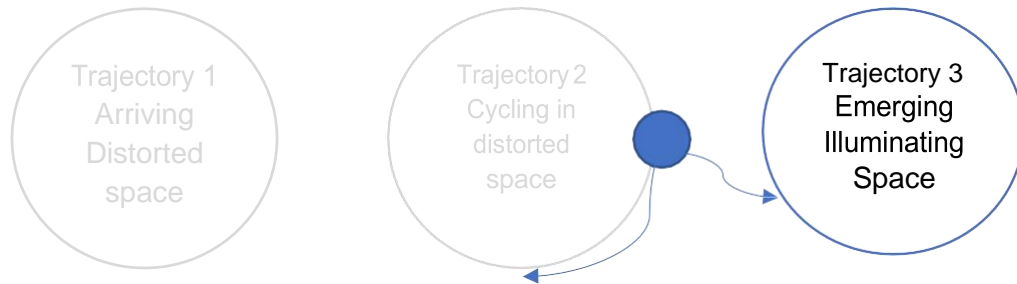
Walking the navigation line was present across both human and unceremonial encounters. *Invoking resistance* was associated with unceremonial encounters and was initiated to maintain freedom and assert an alternative presentation than what was being written by means of the dominant discourse. Inherent in the interviews was the experience of power within the helping context. Participants relayed that they learned what to say to affect unwanted consequences, and by doing so they would maintain their freedom, the freedom to extricate themselves from a situation and retain a decision to die by suicide. Suicide consequently became a protective mechanism. Participants continuously monitored codes and the symbolic position of the nurse, and the expectations assigned as part of that role. At times, the expectation concordant with this role was violated, affecting the participants repose and sense of balance. Distress and tiredness also impacted upon the ability to work out the ‘equation’ to share or not, and this moved power dynamics in favour of the nurse:

‘I think one of the things for me, the more distressed I am the harder that equation is for me to do so I just don’t talk at all then, so it becomes a point of, I couldn’t work out what I could and couldn’t say, so I just wouldn’t say anything and that for me is a complete barrier’ (Bridgette, 103-104).

Walking the navigation line was thus a complex site of interaction, monitoring and weighing up of what is unfolding and informing what is next said. It was a constant interplay of enacted power and resistance as perceived and received.

Trajectory 3 - Emerging in illuminating space

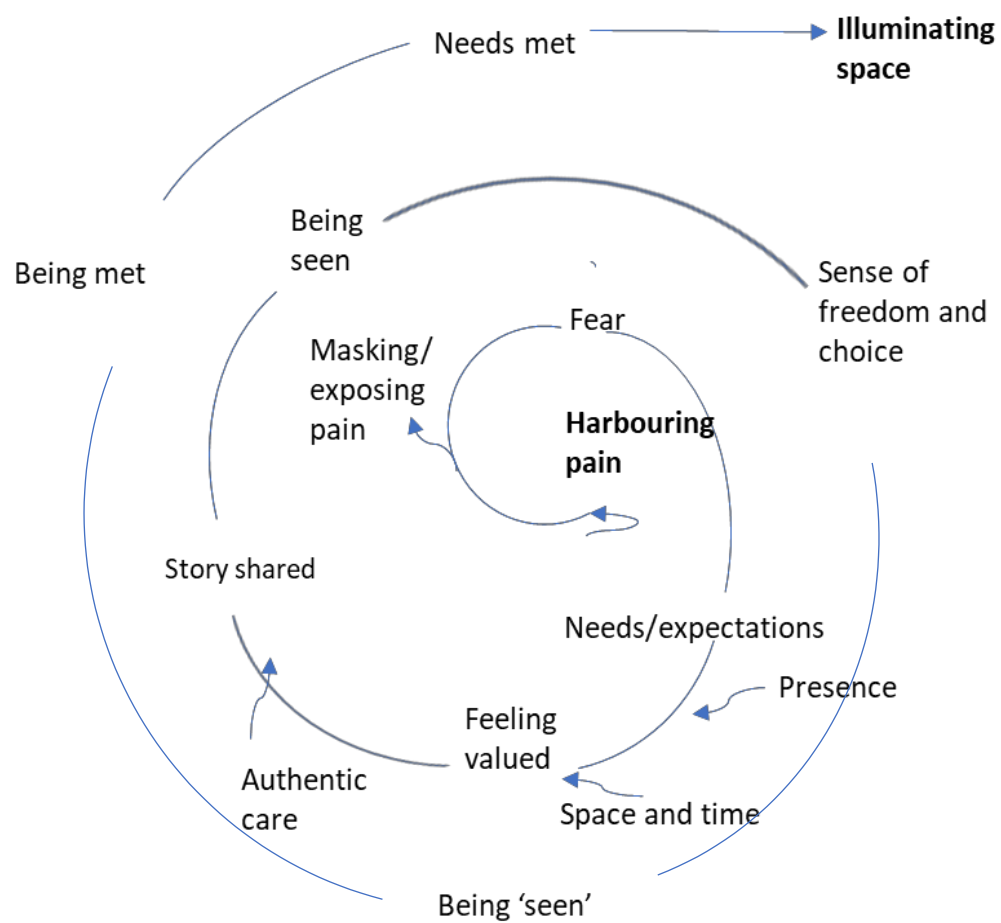
Figure 8. Outline of the journey -Trajectory 3



Occurring from data were critical points of contact that were meaningful or unmeaningful. An *in vivo* code of a human encounter was used as it was a re-occurring word from the participant discourse and translated into theoretical definitions, rather than remaining descriptive. The term captured what participants needed from nurses. In a human pivotal encounter, the helper became the bridge, a symbolic and actual representation of reconnection. The nurse was present and, by being so, validated the other. Illuminating space captured the experience of light, and the healing effects of connecting in a human pivotal encounter (see figure 9, p.84).

Participants shared the view that they needed the nurse to be human and, when aligned, a particular kind of exchange was experienced. By being ‘human’ the helper held a space where both could reside for a while, a place where they could ‘meet’. Being human was difficult to articulate, limited by language, and relayed as a ‘sense’, or ‘a way,’ the sum of more than two people in conversation. Frankl (2004, p. 93-94) captures human exchange symbolised by the exchange of food. He recalls when a foreman secretly given him a piece of bread from rationing in the concentration camp; ‘it was far more than the piece of bread that moved me to tears at that time. It was the human “something” which this man also gave to me – the word and look which accompanied it.’ A kindness, and “something,” is sharing that goes beyond the spoken word. A human pivotal encounter is depicted on the next page.

Figure 9. Human pivotal encounter



Illuminating space; (Context; walking the navigation line. Result; expectations and needs met, collecting anchors)

‘Human’ encounter – presencing

- Time and space
- Experiencing authentic care
- Maintaining sense of freedom
- Seeing me, inspiring hope

In an I-Thou encounter, the helper met with mutual awareness and held time as a durational aspect of intensity as opposed to a sequentially lived through process. Participants referred to space, time, being present and being there:

‘...that is the most powerful thing someone has ever done for me is just to say that I am here for you’ (Bridgette, 215).

Entering the space by the person in distress was gradual, as they sought permission and weighed up

the authenticity of the nurse, seeking qualities such as kindness, care, warmth. The nurse became a reference point to humanity, connecting the person back to humanity, which is reflective of Cutcliffe et al.'s. (2007) core variable of a three-stage process of working with suicidal people whereby stage one was reflecting an image of humanity. Vatne and Naden's qualitative study (2016) reiterates the importance of connecting and experiencing someone who cares as necessary for life when working with suicidal persons.

In a study by Jackson and Stevenson (1998) the gift of time was recognised a key element in mental health nursing. Time and worth were intrinsically linked. By giving time and being present worth and value was constituted. Joan relayed the importance of time:

'You have a person sat in front of you not a set of symptoms. No matter what they are telling you what shape or form, you give them the time, give them the space to unravel, help them make sense of it so they can move forward' (Joan, 339 -340).

When given time participants experienced value. Time created space and a place to 'unravel' to tell a story. Similarly, Shaun offered:

'I just think that if you can treat a person as a human being and listen to them and spend time with them you can make a hell of a difference to somebodies' life' (Shaun, 281 -282).

The notion of time also appeared across interviews and imbues the concepts of linear and cyclical time. Assessments and time with participants were viewed as linear, whereas participants collectively spoke about being caught up in a suicidal world, where this was their world. In addition, the inability to share or unravel through recounting a personal story harboured pain and created a cycling process. Therefore, suicide was not approached in a linear fashion. Instead it had permutations, moved, constantly changed and was fitting with Buber's' notion of time in the space 'between.'

Experiencing authentic care was key to participants feeling able to open and share with the nurse, consistent with Cutcliffe et al.'s (2006) findings whereby human warmth supported the first tenuous links back to humanity:

'I felt open and exposed at first but when they were kind, it made me warm to them... it enabled me to connect a bit more' (Vivienne, 126 -128).

The behaviour and demeanour of the nurse was intrinsic to this occurring. Participants referred to the overall experience of the nurse, and the array of energetic, physical and linguistic properties that denoted authentic space or simply an experience beyond words:

'There was something about them [staff at X] and I can't even pin point what it was whether it was the way they spoke with me, the way they responded to the things I said. There was a real sense that I did matter, even though it was tiny that was a kind of a window of opportunity because you would hear those things verbatim by other staff but you knew they were just going through the motions' (Joan, 149 -152).

There were references to the eyes, a soulful reminder of the qualities of a person:

‘The body language, the way that they look at you, the way that they connect with you, with their eyes... it says more than the words that they use you know. It’s a whole thing’ (Lillian 234 -235).

‘...it didn’t matter what you said to them and you can tell by just looking at somebodies’ eyes. Like for me, when I looked into the eyes of the people at X there was compassion, there was empathy they were none judgemental whereas I have had very different experiences’ (Joan, 98 -100).

Authenticity was palpable beyond the boundary of the physical self, denoting a multidimensional experience. Honesty was also depicted as important in authenticating the encounter:

‘When nurses have made a huge difference in my care it’s because they have treated me with honesty’ (Lillian, 179-180).

Displays of honesty and fallibility connected with authenticity and helped create a sharing, safe space. Participants welcomed an honest response from nurses, such as acknowledging limitations and offering that one was unsure what to do:

‘It’s a hard thing to do saying, I am not actually experienced enough to deal with this. That’s a hard-enough barrier to get over in the first place but if somebody does it, it proves they are human’ (Shaun, 267-268).

Physical contact was a feature of comfort and a gifted response as described by Pauline:

‘A hug, you would be amazed at the difference a hug can make. That can help more than all of the drugs and anything else put together, just a hug’ (Pauline, 219-220).

This illuminates the importance of experiencing human responses to a human response of living, the everyday exchange that one may give or say to another in their life. Vatne and Naden’s research (2016) emphasises becoming aware of the desire to live, connectedness and experiencing someone who cares as necessary for life. Becoming aware of the desire to live and connect reminded the person of their connectedness with others. I would extend this and suggest that the quality of the connectedness is that which awakens desire through the acknowledgement of self as reflected by the other (in this case, the nurse).

Maintaining a sense of freedom. Szasz (1999) argues extensively that people should have the right to choose to live or die without recourse. This was observed in the occupied tension with participants and is consistent with the resistance enacted, as holding onto the ultimate decision to live or die appeared of ultimate importance for participants. It appeared that having a choice of suicide could also be a deterrent, as it was the ability to take the decision that appears to be of most importance and the ability to have space to think through and find another way forward that was key. Although participants and nurses may arrive at the same conclusion i.e. hospitalisation or not, the process of getting to that decision is deemed key:

‘He didn’t judge me he didn’t sort of try to aggravate me, he was very calming the way he spoke was very calming and there was no sort of ultimatums there. He wasn’t saying you have to get over, you’ve got to come back over, or you have to get back to safety. A lot of it was putting the ball in my court and what

did I think and what did I want to do, and did I really mean to do this? He wasn't sort of sanctioning me saying you know your family, what's your family going to think? There was none of that sort of like trying to encourage me by guilt trips if you like' (Shaun, 79- 82).

However, Lillian highlighted the complexity of choice and the moving and changing aspects of suicidality:

'He gave me enough time to make the choice for myself ...when I am in a well place I can make choices...I know what a choice is. When I am not in a well place it is no good telling me that I have choices because the only choice in my head is not to be here and actually that just makes it worse' (Lillian, 329 -332).

Being told one has a choice to live or die is not considered helpful when one is in suicidal distress. Importantly, being human, authentic, kind and caring, and facilitating a meaningful conversation is key:

'I wouldn't want that person to tell me I couldn't do it. I want that person to just come in and say can you just talk to me first?' (Bridgette, 284-285).

'...then just say to the person what do you think we should do next?' (Shaun, 269).

Being seen; experiencing validation as a fellow human being was intrinsic to the human encounter, particularly the novelty of being spoken to as another without focus on being a body inhabiting a diagnosis:

'People actually saw me they didn't see the illness and for all of my life that's all most people ever saw... they actually responded to me as a person not the illness and they actually let me talk' (Joan, 160-161).

Being seen was closely connected to hope and illuminated the interactive space, as seeing someone constituted valuing them through being curious, interested in what they had to say, letting the person talk and responding in a friendly way. Seeing the person, and an interaction constituting worth and value, elicited hope in what was a hopeless situation:

'It was a message, this tiny message that I was worth something and that I could contribute something too' (Joan, 148).

'It was at the lowest point in my life and it was nice to have a stranger have faith in me' (Vivienne, 156).

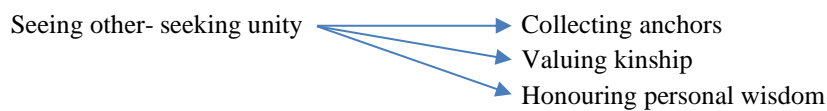
Consistent with participant experiences, Dunkley et al. (2017) express the importance of being heard, central to which is 'co-bearing,' where nurses are present in the here and now. Similarly, engagement, co-presencing and inspiring hope were terms used to capture attitudes and knowledge thought to be central to training in the care of suicidal persons (Cutcliffe and Stevenson, 2008).

The illuminating pivotal encounter was constituted of qualities beyond the physical barriers of self. The nurse sets the conditions for the pivotal encounter, mirroring light to the person who has arrived in darkness.

Emerging - illuminating space

Emergent space captured the knowledge and wisdom gained through the suicidal journey. This was very personal and different depending upon the person's unique experiences, encounters, interpretations and anchors. Shared features were those of honouring personal wisdom and strength gained from the experience of being suicidal. Traversing the outer aspects of self and emerging from this and continuing to emerge was valued.

Some of the participants did not rule out arriving at suicide in the future, as it was an aspect of themselves that they knew. The core feature was seeing other – *seeking unity*, subcategories included *valuing kinship*, *sharing wisdom* and *finding anchorage*. Consistent with Joiner's theory (Joiner, 2005) and Durkheim's seminal work (Durkheim, 1952) of connectedness, kinship emerged as a focal point of emergent space.



Seeing others. Participants spoke of a turning point where they began to see differently. The anchors collected began to have enough weight to stabilise their world and allow the person to see others. Although the pivotal encounter could be a turning point and mutual connection experienced, this was related to a longer-term investment of change; an acceptance of where one had been. David and Lillian offered insights that helped them see others:

‘I know people are under a large amount of stress and they don’t feel like they can properly give of themselves’ (David, 170).

‘I actually teach that to people now and I tell people that story about the fact that actually nurses are just human, and they aren’t mind readers and that actually you have to give the information and you have to give them the honesty and the trust as well as them giving it back to you. It is a two-way process but that took a long time for me to work that out basically’ (Lillian, 18-22).

Lillian’s point is synonymous with personal wisdom and a poignant indicator of the transition from a point of naivety to deep personal understanding.

Personal *anchors* featured throughout the stories of participants. Anchors were significant others who appeared as reminders at times of distress, serving as a momentary connection to a familiar world. Anchors were those of kith and kin, though could also be a positive encounter with a nurse who anchored the person in the world at a given point in time and served as a reminder of worth:

‘...on the Tyne Bridge, as I was talking I was thinking to myself, I have a mother there who is totally innocent in all of this. She doesn’t even know why this is happening and that kind of pulled me back a bit’ (Shaun, 181-182).

‘I would hear her voice at that point when I was about to do it, shouting to kind

of stop... like an internal voice' (Joan, 113-114).

Participants also valued the perception of the nurse, and knowing that such people cared was significant and challenged their current way of thinking about themselves.

Valuing kinship acknowledged significant people present in the person's life during crises and made new connections by the active seeking of others who had similar experiences. There was a primordial dimension to this theme in that it called upon those who had gone before, as they held wisdom and a way of being in the world that offered hope:

'A really important point for me was very early on meeting a colleague.... who was very open about her trauma and her difficulties... was functioning in a way that I aspired seeing her as a role model seeing that and hearing what she had gone through, seeing what she could contribute, that was really important to me' (Nikita, 233-23).

'...that is why I tend to believe someone who has been through it as well who has their own problems and so on you can talk to but is positive and can help you through the negative side of things' (David, 109 -110).

'For me it is about peers, they were really important to come across...people who have been in that place where you knew talking about it, they knew what you were talking about, there was that shared meaning' (Joan, 115-117).

Here, meaning was co-constructed in light of a preunderstanding and a sense of what it is like to be suicidal. Philips relays, 'meaning is a co-construction in two respects: it is produced through intertextual, dialogic relations to other meanings, and it emerges through the collaborative activities of the participants in social interaction' (2011, p.28). Peers were valued as meaning was shared by the joint experience of suicide.

Personal wisdom. Participants were steadfast in their journey through uncharted ground, to the outer edges of themselves. They experienced a force that asserted difficulty in capturing words. The journey endured offered self-knowledge, growth and development and a sense of strength:

'I think I have realised that it doesn't matter what people think of me I have gone through that experience...Now actually, I know I can say anything. If someone doesn't like it [that I am suicidal] or someone is being judgemental about it, then that's their problem not my problem' (Vivienne, 212 -217).

There was an acknowledgment and acceptance that suicide remained a feature in life to a greater or lesser degree, though through experience an emergent relationship was fostered and, with that, familiarity:

'I know I am never going to be cured. I do go into these tunnels I have been in a tunnel for the last two or three weeks but I know if I just keep going I will come out of the other end and I will be stronger than I was when I went in and I will have that experience, I'll have that understanding and that knowledge for next time and that makes a massive difference' (Patricia, 82-84).

Shaun's use of language denoted a shared approach to suicide in that 'we' can overcome it; this emphasised the depth of unity and shared approach to supporting suicidal distress and echoed

Bridgette's earlier point of hearing 'I am here for you,' a togetherness in getting through:

'I felt suicidal a few times, but I look at it differently now and I have a network of people around me who I can talk to about it, so we can overcome it' (Shaun, 299 -300).

The person was able to move beyond suicide as an answer to pain. This could not be forced and, rather, is a process of convergence:

'Now I think suicide is not the answer. I think that you have to work through whatever it is that has taken you to that point. But if you had of asked me that question a few years ago I would have said suicide is the only way to make this pain stop' (Nikita, 8-10).

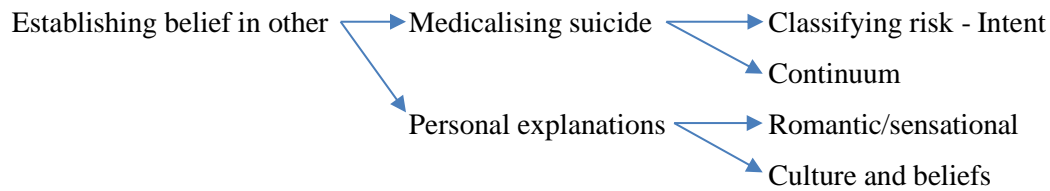
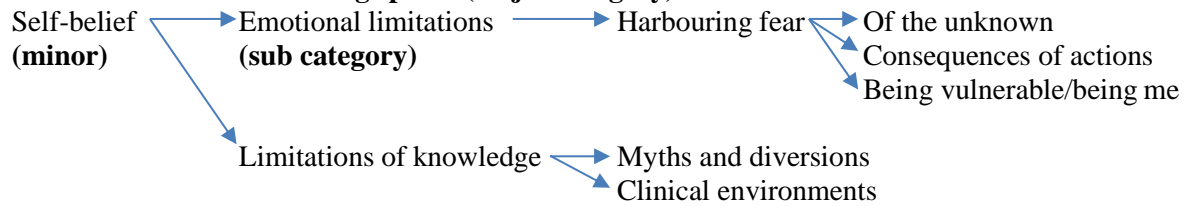
Through cycling, participants gained insightful knowhow. Interestingly, five of the participants were involved with teaching clinicians at local Trusts or recovery colleges. Through experience, they offered advice to nurses and sought ways to share these experiences.

Findings from student nurses are presented in the following section. The major categories and subcategories are expressed in the same way as above. Whereas pseudonyms were utilised above for participants, each student nurse was referred to by code (due to the number of student nurses participating). MH refers to mental health student nurse followed by the number of the student, followed by the focus group number and the line numbers of the transcript. Adult student nurses are referred to as A.

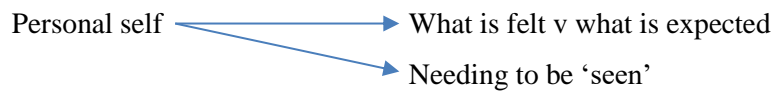
Findings and discussion – student nurses

Major categories, minor categories and sub categories

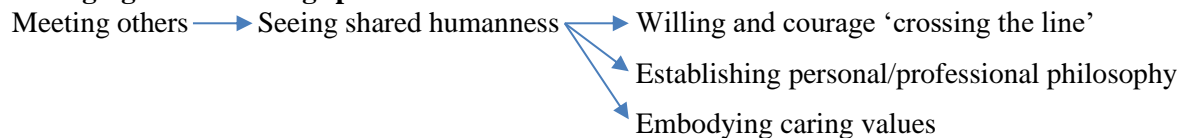
Lost in translation -Limiting spaces (major category)



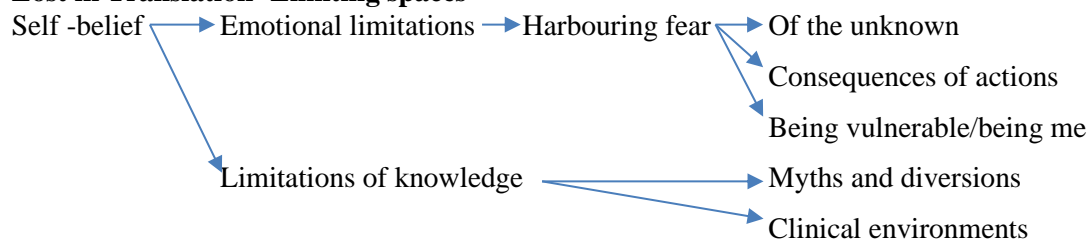
Experiencing Dissonance - Distorted spaces



Emerging - Illuminating space



Lost in Translation -Limiting spaces



Lost in translation – limiting spaces

Lost in translation referred to the consequences of acting from the limitations of self-belief and establishing belief in others. This created limiting spaces. In limiting spaces, the student nurse was unable to see the other as they are too focussed on self or determining ‘truth’, rather than hearing a story and being with the suicidal person. Occupying these spaces was limiting in relation to students feeling unable to enter conversations about suicide with another, and thus created limitations within the pivotal encounter.

Emotional limitations. The pre-occupation with self and fear of the unknown was salient in this category. The *unknown* was significant in that suicide was an abstract concept for some students, and their reported inability to understand the other placed them on uneven ground from the outset:

‘I don’t know what part of your life you would have to be in to go that far so to understand that and try and help other people...’ (A2, 220-21).

‘I think you have to be in a certain place that no else will know what that feels like unless you have been there, it is so specific to that person’ (MH2, 19).

Gilje et al. (2005, p.522) highlight the importance of life experience providing critical insights into existential aspects of the human condition. Connecting with past experiences makes the present applicable. The past as a reference point of experience would also contribute to the acquisition of knowledge:

Interviewer: ‘What does it feel like, recalling or thinking about having a conversation about suicide with a person you have just met?’ (1177-181).

MH3: ‘It’s your own anxieties’ (1179).

MH6: ‘I would be so scared that they would say something I didn’t know’ (1180).

MH3: ‘Or say something you did know, and you were frightened you gave the wrong information. You are frightened that what you said has took them the wrong way’ (1181- 182).

MH2: ‘I think you would need courage, I think it would be really hard to ask somebody if they were feeling suicidal you would need to know what to do and what to do with the information and if somebody says they are feeling suicidal how are you going to safeguard them, stop them’ (1168-169).

Student nurses detailed their own personal response and were concerned with this as a priority. The response was focussed on safeguarding and stopping the person from dying. There was a sense of immediacy as reflected by anxiety and fear. Herein was a salient difference between student nurses and participants who had experience of suicide; student nurses wanted to stop the person taking their life, while those who were suicidal wanted to stop the pain (Freedenthal, 2018). Participants were aware that the nurses they encountered were concerned with risk. The conversation above also demonstrated themes of lack of knowledge and feelings of fear and anxiety. This is consistent with Cutcliffe and Stevenson (2008b), in that working with suicidal people can be stressful. Given the

comments it was clear that student nurses found the idea of conversations about suicide challenging because it created negotiation of personal and professional boundaries, consistent with findings by Gilje et al., (2005).

Also, in this category was *consequences of action*. These were twofold: consequences of talking and impending further harm to the suicidal person (Valente, 2011) and consequences to job role due to a blame culture. This was a significant feature. There was a lack of literature exploring how clinicians perceive and experience organisational support when working with suicidal people. The excerpt below highlighted the fear of the consequences of action in relation to policy and law:

‘It really depends on what the rules are according to the policies now isn’t it? I totally agree with what you are saying. I would be inclined to bend the rules in regard to things like that, but people are frightened because it’s their lives and people are selfish and start thinking I have worked so hard to do this and it might be taken away just like that’ (MH1, 413-415).

‘Your own judgement can be wrong and then how do you justify that if you got took to court you can’t say well *I thought* because it doesn’t stand, do you know what I mean?’ (MH3, 1419-420).

‘I suppose if you can justify yourself though and you say well, I thought it would have prevented this person from committing suicide or something I kind of think you would have a leg to stand on’ (MH5, 1422-423).

The student nurse above referred to ‘bending the rules’. It was interesting to note that this was code for sharing through self-disclosure. A clear tension was noted between the students, one advocated a steadfast policy response to suicide, the other referred to clinical judgement and the aspect of offering a human response, further replicating the tension. Student nurses looked for safety within process, solidifying the focus on assessment:

‘But if you said somebody could go out on Section 17 leave and you have done your risk assessments and everything and they have killed themselves, if you have done everything right...’ (MH1, 1437-438).

‘But would you ever get over it as a person yourself thinking, was there something else that I had missed? You see I don’t think you could get over that as a person’ (MH3, 1439-440).

The responsibility of job role and the tension created within the areas discussed rendered some students *vulnerable*. There was an active departure of humanness from procedure and professional role which will be discussed further on.

Limitations of knowledge

Myths and diversions. The idea of distracting the person from their suicidal thoughts was well meaning, though indicative of avoiding the underlying emotional pain:

‘Or knowing what the triggers are if they have an anniversary coming up and if you have been around that person then you could try distraction techniques and stuff and be there and work them through it, do it with them so they are not so focussed on it, like ending their life but bettering themselves and working with that, with the different techniques like Occupational Therapy and things ...like

art might be their thing or music' (MH5, 196-98).

An interesting diversion from asking directly about suicide was integral to comments made by some students who believed that such information would be offered if the suicidal other wanted to share. This reflected some of the findings in the literature. Student nurses suggested that a positive relationship was enough, and people would share regardless. However, a positive relationship as viewed by the student nurse may differ from the view of the individual who is suicidal. Secondly, it suggests that students would disinvest searching for information, waiting instead for the information to be offered:

'It's building up their trust with you as well before the subject is even approached. Let them approach the subject if they want to talk' (MH3, 1100).

'If people are comfortable with you they will open up and tell you everything' (A1, 1101).

There was reasoning that no matter how much of a positive environment was created, people would not tell the nurse that they were suicidal. One student suggested that people may be embarrassed about being asked directly about suicide; again reflecting overreliance on sharing by the suicidal person and justifying reasons for the nurse not to ask, creating further avoidance of a conversation about suicide.

The actual word suicide was heavily laden, and student nurses avoided using the term altogether, preferring alternatives. This suggested that even if students were to ask about suicide, they would not ask directly. Following are comments from first- and second-year student nurses:

'Yes, you have to ask it but sometimes I would try and ask them first have you got any unusual thoughts at the moment or just not getting that word in there' (MH3, 1281-282).

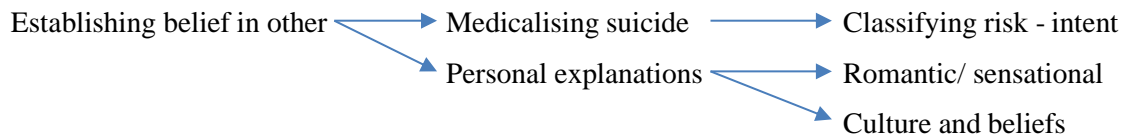
'We say are you feeling a bit down about anything and a lot of the time we [clinical team] never use the word suicide' (A1, 1284).

Influencing myths captured the myths related to suicide and how they influenced student nurses. The myths are evident throughout the examples (if the person meant it, they would not share. Further examples are scattered throughout the next category). The myths above are regarding sharing or not sharing suicidal thoughts.

Student nurses started the interview by relaying empathetic responses to suicide (what was expected) but when deep in conversations they acknowledged the difference between what they should say and what they had experienced in some areas of clinical practice. Biased responses were dominated by the expectations of the influencing institutions such as the NMC and the employing organisation. Encouraging time with the suicidal person and being there with them was recognised as limited and rare in practice. Student nurses recognised limitations in appropriately sharing experiences and voiced an expectation that suicidal persons should share if they were asked about suicide. There was

limited consideration of a therapeutic encounter and an expectation that deep personal feelings and thoughts should be rendered available at a simple request. This is a classic example of the needs of the individual coming in direct contrast with the nurses' overriding obligation. This is succinctly captured by Rudd et al. who explain the nature of suicidality is seen as a right by the individual, as opposed to the nurse who has a statutory and professional obligation to prevent suicide (2001, p.113).

Also, under the major category of *lost in translation - limiting spaces* are the following:



Establishing belief in other. Most of the student nurses (apart from one adult and one mental health student nurse) were preoccupied with establishing belief in suicidal persons. Efforts were focussed upon a truth claim; that is, was the person suicidal or not? Unfortunately, myths were prevalent within this category too. These were beyond the personal influencing myths that prevent asking about suicide. These myths included the belief that those who attempt suicide do not mean it, and those with multiple attempts or self-harming behaviour also did not mean it. This contrasted with findings from research literature. Research reports that people who self-harm are more likely to die by suicide. According to Chan et al. (2016), self-harm elevates the risk of suicide to between 50 and 100-fold in the year following self-harm. Intent is assessed during the assessment of suicide but in the case of many of these student nurses it is translated through many lenses such as prevalent myths about suicide, stigma and personal and cultural influences. The suicidal person arrived for help and unknowingly had something to prove to penetrate the stigma, myths and the search for truth by the student nurse. The student nurses essentially started in a position of mistrust. Talseth et al. (1997) identifies mistrusting patients as a subtheme for distancing from patients. Although the nurses in their study were qualified, it appears that techniques to distance from the difficult subject of suicide are also applicable to student nurses in this study.

Medicalising suicide – risk and intent. Intent did not feature in the language of the participants in in the previous section. Feedback from participants during member checking sessions established that intent was not relevant. They offered that an attempt was an attempt and they intended to attempt suicide. It became a redundant discussion for them and was considered meaningless. Conversely, intent was a core feature for student nurses in establishing belief of the person.

‘How do you know how true it is [that the person wants to die]? It is awful to say but sometimes you don’t know?’ (A1, 1204).

‘When I don’t know sometimes I think they are just saying it because they are angry with someone?’ (MH2, 1205).

‘I have seen people saying they are feeling suicidal to get a one to one in the

coffee room with the psychologist and get the biscuits.....but it is still logged as them feeling suicidal on their notesso they are using privileges...they have said this because they wanted to go for coffee it's just goes on' (MH5 ,1206-208).

The student nurse referred to one-to-one time over tea and biscuits as a privilege and failed to refer to the benefit that this may bring to the person. The following third-year student was empathetic in her response to considering intent:

'I don't think we should measure it. Who are we to stand there and say this person needs more help or they intended to do it more? I do think this happens in practice though, you do hear it' (MH11, 31-82).

Beyond not knowing and gaining attention and revenge through anger, this student nurse introduced the notion of the seriousness of the intent and how this is judged:

'It's about a chance of whether you can come back from it or not, people don't think it's a serious attempt if they think they can come back from it' (MH3, 79).

Intent fits with the criminal standard of proof used by coroners to establish the intent to die by suicide (see chapter two p.19). It features in risk assessments and the language of nurses as identified by the participants in the previous section. The efficacy of this is questionable in the place of nursing care. If the focus of nursing is interpersonal relationships and establishing meaning to what is occurring, then the focus is about understanding personal choice and what brought the person to this space.

Intent and establishing belief became an area of complexity. Interestingly, the focus on intent by student nurses contrasted with the redundancy expressed by the participants. Brown et al. (2004) report a minimal association between the degree of intent and lethality. They note that the accuracy of expectation of the likelihood of dying (as viewed by the person attempting suicide) moderated the relationship between suicide and lethality. The belief of the lethality from the person's perspective is crucial and, therefore, it is this that needs to be established in a suicide attempt. This adds a critical perspective on gathering information from the person regarding their belief of how they would die. It closely represents findings from the participants in this research. Method is personnel (Shneidman, 1996) and respect is needed for each situation, instead of assuming lethality of method as an objective measure of intent. The excerpt from the focus group below demonstrated how student nurses linked intent and lethality of method. This impacted upon how 'risky' the individual was considered to be:

Interviewer: 'So if someone comes into hospital with self-poisoning for example, is this considered differently to someone who has jumped out of a window or off a bridge? (326- 327).

MH13: 'It's the visualisation of it isn't it, you can't see the injuries you can't see the impact of the overdose or the physical attempt of the suicide therefore I don't think it's taken that seriously because you can't visualise it' (3328-329).

MH9: 'If you say they are attention seeking then what are they attention seeking for, if that's what people say, what is it about, realising it's not just that behaviour there's a reason behind it' (3330-331).

MH12: 'My view is that if you jumped off the bridge, out of a window or hung yourself then you would not be seen because you are dead or more likely to be so it's like, if someone didn't attempt it in that way then they didn't mean to kill themselves' (3332-333).

MH11: 'Yeah it's like you would not have been found in time' (3334-335).

Another student challenged the idea of intent regarding method:

'Whatever you talk about timing, method, it all has to be thought about so there must be an element of intent. You have to go and buy the rope, the tablets, you have to make sure you have got enough, you have to go through that process. It's not about the time it takes, it should all be taken seriously because it's about the act of committing suicide, doing it and taking the time to do it' (MH9, 368-77).

Establishing belief was mixed up with the interpretation of the term 'cry for help,' first termed by professionals and now in general parlance. Unfortunately, the term has changed by the shifting sands of time. It is often used to resemble 'attention seeking,' and is translated as; do not give attention: the opposite to what it was coined to represent in the first instance (Kahn and Earle, 1982, p.1). A mental health student nurse referred to the 'size' of the attempt as a cry for help:

'There are different levels of it as well some people make really big attempts and others make superficial attempts like a cry for help. They make superficial attempts that could go wrong, and they have' (MH5, 133-34).

Violent acts are considered authentic in relation to intending to die, whereas anything else is judged to be a cry for help or not serious. The act of sharing thoughts about suicide was considered attention seeking; in this example, the person was in a no-win situation:

'If she was going to tell you everything she wouldn't do it. I think it would be more for attention if anything, because if you really wanted to do it you are not going to tell anybody' (MH3, 268-269).

This creates a problem when advocating suicide awareness and prevention strategies as it supports the reduction of stigma and encourages people to come forward and seek help if they are suicidal. *Establishing belief in others*, as expressed in the research here, suggests that people would not be taken seriously by some if they did come forward asking for help. Many statements from student nurses collectively demonstrated judgement and a lack of understanding of the suicidal person.

The act of being non-judgemental runs deep throughout nursing literature and is referred to explicitly in the code of conduct for nurses (NMC, 2015). Here, many students were acting in a judgemental way with the risk of this impacting upon care. Smith et al. (2015) used the term 'dysregulation' to refer to the maladaptive responses provided to suicidal patients within health services in the UK. They identified a patient's distress as disturbing to clinicians. This created negative feelings about patients, resulting in a narrow focus on diagnosis and assessment, and abrupt and ad-hoc decision making. Maltsberger and Buie's classic study (1974) noted negative reactions of therapists to suicidal individuals. They specifically termed this 'countertransference hate.' More recent studies (Yaseen et al., 2013) have found consistencies with Maltsberg and Buie's framework, noting that clinicians

reported feeling overwhelmed and distressed and often avoidant of suicidal persons. Joyce and Wallbridge (2003) list anger and irritability as responses to suicidal patients. The use of the term 'hate' appears to be harsh and perhaps misses the emotional basis of fear and misunderstanding which reoccurs throughout the literature and is prevalent in this study. The resulting presentation is that either way the suicidal other is not only struggling with their distress but is also up against interpretation and judgement whilst nurses attempt to work out if the person is to be believed. Research literature (Scheckel and Nelson, 2014) suggests that supporting students to better understand their own attitudes and beliefs is necessary when working with suicidal people, purporting that fear impacts upon the nursing care delivered.

Personal explanations: This subcategory incorporated the romanticising and sensationalising of suicide and how this informed a response to the suicidal person:

People think it a nice way out don't they? Paracetamol, overdose a nice warm bath and you fall asleep, that's the romantic view, that it will be peaceful and beautiful. There's always discussion about time period when they organised it and if they were going to be discovered in some way shape or form (MH10, 3150-52).

It was difficult to separate from personal and cultural beliefs as these all contribute to personal perspectives. Suicide, in this category, was a normalised word that failed to ignite emotion. The student nurse spoke about other people's responses to suicide in the first instance then moved into presentations from media and the subsequent impact of this. The idea of sensationalising suicide was shared by other students in the group and appeared to create inertia rather than a compassionate response:

'Just because of my personal experience from the area I grew up it's not such a harsh word to me. To me it is just like normalised. Over the past year we have had three suicides just in my village. So, it is more normalised now, but I can still understand that other people, especially the older generations still shove it to the side sort of thing. They just don't want to talk about that. I think especially on the news as well, when you see it, it is big stigma and stereotyped and it is always very dramatic the dramas on TV and the soaps, it's just made into such a big phenomenon' (MH6, 1286-289).

Personal exposure to suicide in the direct community was referred to as normal. Students relayed that suicide was too exposed, and that speaking about it in society created stereotyping and therefore did not help the cause:

'I think especially when it is happening in your local community if it is like superficial attempts..., I know where I live that really has clouded people's judgement and they just roll their eyes to it and they don't take it very serious' (MH 2,1135-36)

Students connected suicide attempts with self-harm:

'It is the same around mine at school as I have just left school and like I think it's like a big thing now like lasses cutting their arms and stuff. I don't think people see it as a suicide attempt it's just the new fad. I know quite a few lasses in my class at school with a few cuts on their arms and stuff and I am sure it

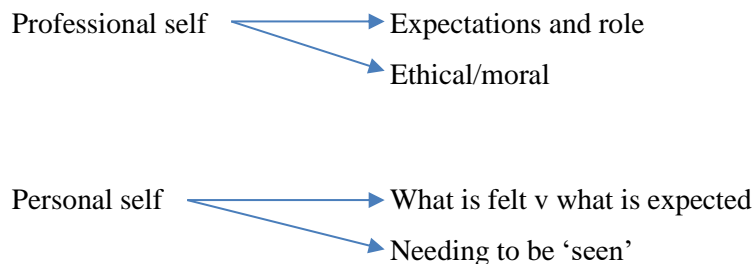
wasn't a suicide attempt it was just because others were doing it' (MH5, 137-39)

'It's like a fashion trend isn't it' (MH4, 140)

The repetition of an expression of pain in this case became intolerant and the person and the person's communication is lost in translation. A systematic review of the literature (Daine et al., 2013) regarding internet use by youth who were suicidal or self-harmed concluded that self-harm can be normalised by internet use. This connected with the observations of the students and may offer some explanation about the stigma surrounding suicide, especially if self-harm is considered a trend, and self-harm and suicide are connected by the student nurse posing judgement.

The major and minor categories of limiting spaces represent the limitations placed on a human pivotal encounter occurring between a student nurse and a suicidal person.

Experiencing dissonance - distorted spaces



Distorted spaces represented the dissonance occurring for student nurses in the context of professional self and personal self. Dissonance arose when there was discord between what a nurse believed and what they thought was expected of them as governed by the code of conduct for nursing and midwifery and mental health law. The following excerpt summarised the conflict that was noticeable across all interviews and demonstrated the dissonance between professional and personal self and an uncertainty of expectations within certain roles. Gilje, Talseth and Norberg (2005) conclude 'struggling with self and sufferer' as a main theme in their research, and the excerpt below demonstrates this tension experienced by student nurses:

'A lot of pressure on yourselfit is doing the right thing with the information, so do you look at them being a little bit selfish because if they are thinking about doing that, they are not only being selfish to their family they are being selfish to the people who are trying to help them and putting all this pressure on to someone who is trying to help them' (MH4, 1201-203).

Expectations and role: Student nurses tussled with identity and role:

MH2: 'You feel accountable all the time as a nurse it's like with CPR now if you are in the public you have to do CPR' (1380)

A1: 'So things like that it is your duty in that moment you go back into your

role' (1381)

MH3: 'But it is getting rid of that stigma that we are a nurse and not a person and it's getting rid of that stigma' (1382)

A1: 'But at the same time we still want to be in a profession don't we and we want to be respected like that' (1383)

Few students were able to articulate that they brought themselves to the situation and that they could still be professional by doing this.

This demonstrated a struggle with the distinguishable nursing role and personal responses. There was a discernible feature of students devaluing their role and viewing it as devalued by others in need. Offering help outside of the job role was associated with kindness, yet it was considered an expectation and therefore less meaningful when offered at work. This somehow rendered the intervention less meaningful:

MH6: 'If you are a nurse in a hospital that is what you have wanted to do for your life that is the career you have set into but if it's a person on the street it gives you a bit more thought actually maybe there are people in the world who care and like there is some sort of point there is a way through, whereas in the clinical setting it's just their job it's what they do it doesn't mean that the whole world is like that' (1359-361)

MH2: 'I think as well as a nurse you are supposed to know what to say but a person on the street there is no pressure' (1362)

MH3: 'You help because you want to help there is nothing telling that person that there is something in place to make them want to help. They have helped and stopped to be kind and I think that will come across to the person what his initial reaction is and that's going back to what we said earlier on about just wanting somebody to care' (1363-365)

The display of negative emotions or confusion over identity in nursing is explained by Turner (2014). Often, the expression of such emotions is synonymous with the discordance in identity in a given situation and the situational expectations of networks, social structure and culture. Individuals may have to alter their commitments to an identity, and accordingly seek out a new one compatible with the situation (2014, p.102). Discordance was expressed by some students regarding which identity to assume in the situation: personal self or professional self.

Moral-ethical: In a two-part paper, Cutcliffe & Stevenson (2008a,2008b) provide a compelling presentation of the moral distress that may occur in nurses who believe that suicide is a personal right whilst operating in a system expected to prevent people from taking their own life. Rich & Butts (2004) term this 'uncertain moral ground', presenting the tensions and paradoxes in greater detail than this section can do justice. Legal and professional positions are highlighted through exploring the Mental Health Act Code of Practice (2015), presenting an understandable portrayal of why nurses become conflicted. While there is an emphasis on preserving safety and preventing harm, the nurse must also consider capacity, bearing in mind what appears to be an unwise decision may not denote the person as lacking capacity. Herein lies the tension: the nurse is accountable and responsible for

actions and omissions. He or she is bound by the code of conduct and law and must consider and assess capacity of the individual in the context of a meaningful conversation whilst espousing the person's view of human rights and confidentiality. All of this is done whilst potentially struggling with their own moral perspective and the counter argument of 'rational' suicide:

‘Your hands are tied in a certain respect in a lot of things to do with nursing, all the new legislations which stop you from trying to be that caring nurse’ (MH3, 1398).

The moral and ethical tensions were peppered throughout in relation to the right of someone to take their own life. Szasz constructs a strong argument for suicide prevention being nothing more than deception, stating ‘Dying by suicide is legal. Attempting suicide is not’ (Szasz, 2011. p.ix). He argues that at the end of any suicide prevention approach or national programme lies the ability of the medical profession to enact deprivations of liberty and coercions such as hospitalisation and treatment against the person who is ‘a danger to himself’ (p.x). Mental health nurses can discharge a nurses’ holding power (Section 5(4), Mental Health Act, 1983) in emergencies and in the absence of a doctor. The moral and ethical tension of discharging this holding power is significant when weighing up if the person is considered ‘a danger to himself,’ as Szasz writes. First the nurse must notice this as an option and then decide if it is appropriate. The student nurses demonstrated the moral and ethical debates that re-occurred throughout the interview:

‘Showing them what other opportunities are out here other than doing that I mean who are we to say no you cannot take your own life. I mean it’s your life at the end of the day you can do what you want’ (MH 4, 170-72).

I know where you are coming from but saying like if somebody said I am going to commit suicide they might get sectioned and that, so you can’t I know its somebody’s life, but you can’t just say it’ your life so you can just go out and kill yourself. (MH3, 173-75).

Tensions were highlighted in the expected response as person, professional and someone who can discharge legal power. This was notable in ‘walking the navigation line’ in the previous section:

‘As nurses we also need something off them, we need honesty to be able to help them because a lot of them might not be as honest and open if you are trying to work with something, that’s why you need to build up that two-way relationship. We can give as much as we possibly can but it’s like with any conversation it needs to be a two way thing’ (MH41235-237).

Expectation, role and moral and ethical struggles can be represented by the concept of ‘knowing you-knowing me’ (Jackson and Stevenson, 2000). The three ‘me’s’ describe the layers of performance the nurse is required to perform to meet the person and their needs. These include: ‘ordinary me’, ‘pseudo-ordinary/engineered me’ and ‘professional me.’

Personal self: Students expressed the impact of working with suicidal people and tussled with how they should respond, either as themselves or in the role of nurse.

What is felt v. what is expected: There was a sense of wanting permission to feel and express the difficult emotions that suicide roused in them:

‘It can be quite overwhelming for us’ (MH6, 1195).

This is consistent with findings from research whereby nurses considered it a great emotional impact when caring for suicidal patients (Long and Reid, 1996). Nurses reported feeling overwhelmed and powerless (Wilstrand et al., 2007), and unable to change the suicidal behaviour, relaying that death by suicide was inevitable for some (Carlen and Bengtsson, 2007). There are some similarities reported by qualified nurses and student nurses in this research.

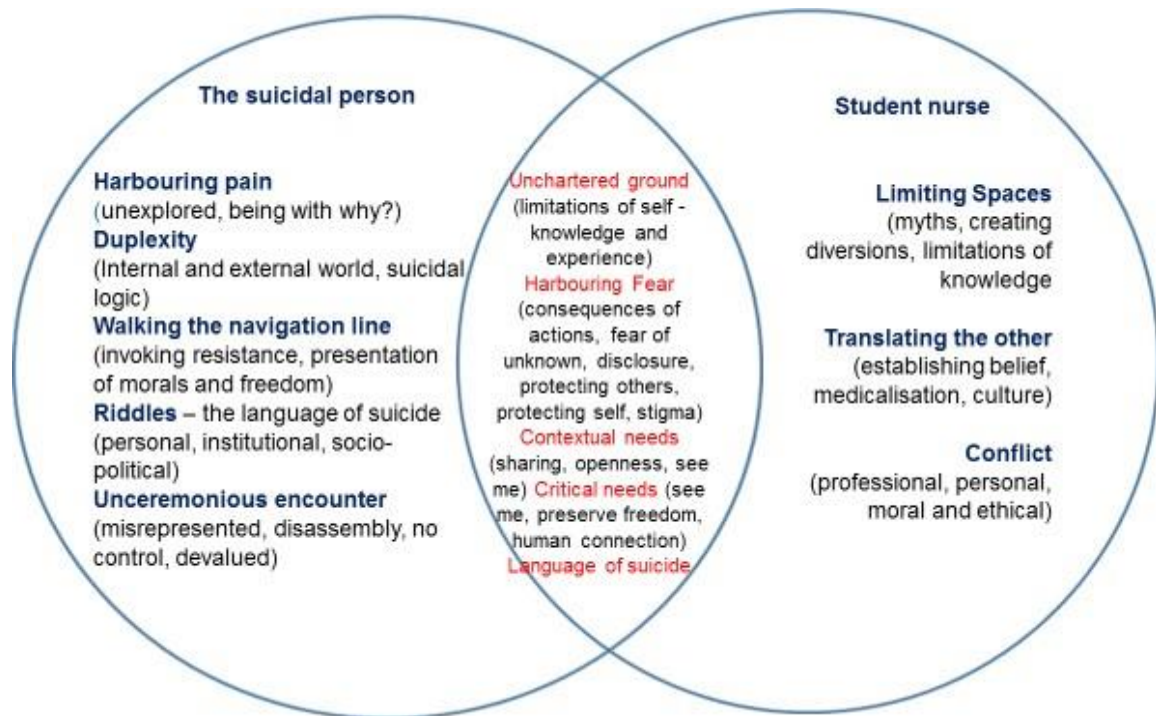
Some student nurses were frustrated with being a nurse and wanted to be a person. They wanted the person to see them. They were unable to recognise that this was possible in the process of genuinely *meeting* the other. Stevenson, Greives and Stein-Parbury (2004) refer to internal and external understanding, whereby nurses become overly concerned with what they can do (external) rather than focussing on internal understanding, that is, what it is like for the person.

Needing to be seen: In this category the student nurses were reflecting the needs of those who are suicidal. Both parties wanted to be seen as a human being, as a person. Students thought that the role identity of nurse somehow prevented this and there were limitations on occupying the space of nurse. The irony is that participants needed the nurse to be human. The term nurse was symbolic, and the nurse was expected to represent this. Understandably, the students were struggling and working through what this meant in practice.

The focus group created a forum for understanding of the students’ own anxieties and confusion. One student remarked that she felt better knowing that her peers shared similar concerns about talking to suicidal people. Students appreciated the time to talk about suicide, not knowing what they needed as they were unsure of what suicide did mean, thus uncovering complexities and muddying the waters further. Students did value the perspective of the person who had experience of suicide and wanted to hear what was useful.

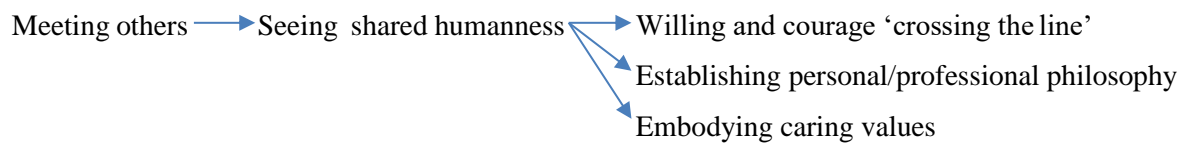
Elements of *limiting spaces and distorted spaces* appear to contribute to an *unceremonious pivotal encounter*. Similarities can be mapped showing elements of overlap between participants and student nurses. I have created an overlay of categories in the ven diagram below to demonstrate this.

Diagram 1. Ven diagram showing dominant feature of an unceremonious pivotal encounter



Emerging in illuminating spaces

Illuminating spaces refers to the moments of meeting.



Meeting others: Students in this category were the exception rather than the rule. They consisted of two mental health students and one adult. One student was a mature student. The remainder of students articulated glimmers of this but had not moved to the point where they were embodying it. They were in the process of translation and would hopefully arrive at illuminating space. There is no guarantee that this will occur given the influences noted in *Lost in translation - limiting space* (p.108). Similarly, to participants, students moved from preoccupation with themselves to seeing others:

‘To me, as a human being and as a nurse you have to see your patient as a human being. It’s the very bottom line that no matter what else is going on they are a human being and they deserve that recognition from you. If it takes that to connect with them then I think it is justified definitely’ (MH7, 2,282-283).

Will and courage - crossing the line: In his seminal work, Fox (1959) introduced the term ‘detached concern’ in relation to physician-patient relationships, describing the need of a balance of attitudes between being sufficiently detached but concerned enough to give compassionate care (p.86). As Cadge and Hammonds emphasise, subsequent focus in the literature tends to be on the detachment rather than the concern, noting the emphasis to be a likely reflection of the health care workers’

difficulty in maintaining distance (2012, p.268) and the misrepresentation over time of the term as a dichotomy rather than a duality (Fox, 2011). The student below emphasised the focus of care for him, though there was little in the notion of detachment, this reaction constitutes daily care, the emphasis of relationship building and connecting to individuals.

The concept of crossing the line was interesting in that it suggested a deeper involvement rather than detachment:

‘Yes, am I crossing the line here if I sort of enter in to this human relationship with a person do you know what I mean? You are getting close to them as another person rather than as a patient and a nurse’ (MH7,2276-277).

Buber (1958) refers to this as ‘the between’, a relational space created by the encounter of I -Thou. Buber adopts a holistic view of dialogue and communicating between persons, in that he views others as whole and therefore authentic communication takes place on this basis:

‘I agree, I think there is a professional boundary there but I think especially if you are talking about someone who is suicidal, it’s such a personal sensitive thing where you have to be yourself. I think it just draws it out of you’ (MH7,2261-262).

This first-year mental health student nurse shared the essence of connecting with the covenantal nature of nursing and being with moment. The adult student nurse shared a similar view and related this to her experience of death and dying in clinical practice. She expressed the need to review boundaries in each situation, touching upon the softness of boundaries and what is required to show humanity:

‘There are boundaries there, professional boundaries about you know, sort of closeness and things like that. You can’t get too close to people but I think it depends on the situation as you also have to be able to decide whether that’s needed, you know you have to build a relationship which has to be a professional relationship but you can also show your humanity as well. I think that is very important in that situation, that you connect with someone as a human’ (A2, 2257-260).

Courage was also noted, particularly the courage to view boundaries and move out into borderlands:

‘It’s part of courage isn’t it? Obviously, it goes back the six ‘Cs’ you know you have to have courage to stand up for things that are wrong but also to have difficult conversations’(MH72185-186).

Implicit to this category was the emergence of a changed relationship with the suicidal person. This was found by searching and connecting with personal values, ethics and meanings given to living and dying. Through this, the boundary between nurse and patient was permeated by the students realising that the only way to connect was to extend out and be human. Not all students had reached this place. Some remained in conflict whilst others emanated a comfort from demonstrating care. Consistent with the needs of the participants discussed earlier, a minority of students comfortably articulated the need to be present and to listen, embodying caring values:

‘I think you just be with them and not just there as a you know, a person. Be close to somebody if they will let you instead of you know, don’t sit on the beds and that sort of thing. Sit on the bed, sit next to them, hold their hand whatever they need, allow them to talk and just give them that time. I think it’s like that little cartoon where someone is depressed and they are wrapped up in a blanket and another person comes along and gets in with them and it’s kind of that idea of not standing outside. Just be there with them in that moment then you can step back again to a more professional role, but if someone is that distressed you just need to be there’ (A2, 2289-293).

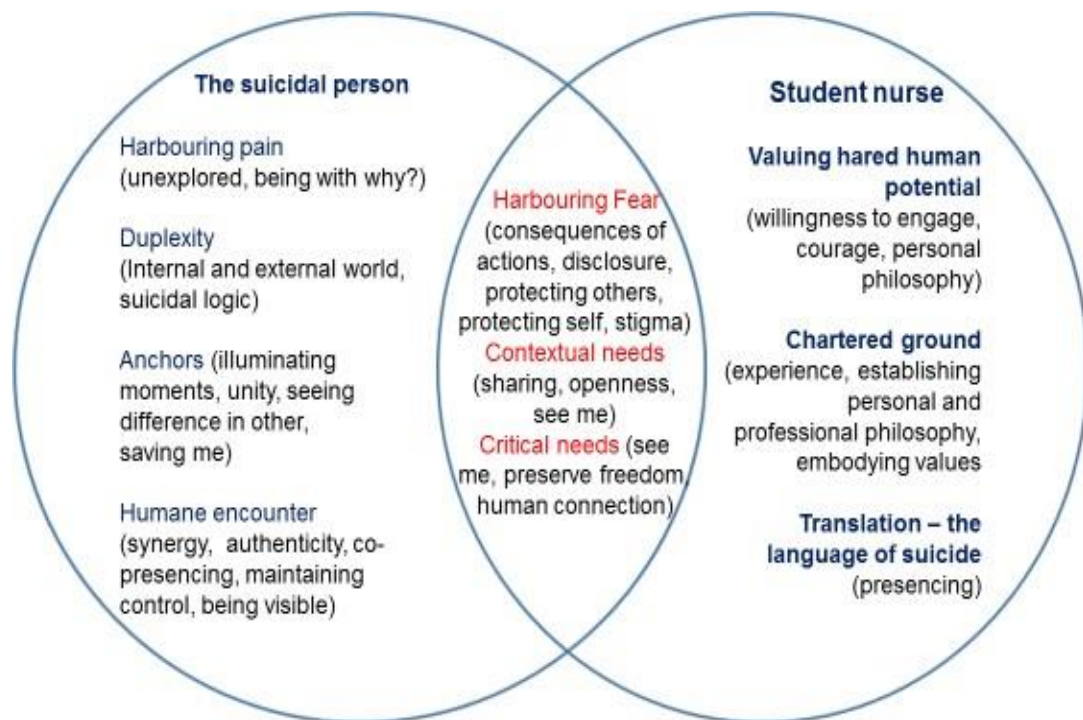
The student nurses recognised that they held anxieties, but this appeared to be expressed as secondary to the person’s needs. There was comfort with the idea of caring and nursing, and what this constituted. It was emphasised by a shared team ethic, knowing that support was close by. This helped with role clarity.

Student A2 demonstrated her limited knowledge but saw honesty as being key. This was consistent with remarks from participants in the previous section:

‘I suppose you can’t understand how they feel but you can maybe let them know that you are trying to understand how they feel and that you want to talk to them, and that they are worth talking to and you are willing to listen. If they will talk, just listen’ (A2, 281-82).

In illuminating space, nurses were able to ‘meet’ the person and co-create a human pivotal encounter. The ven diagram below shows a shared overlap between the nurse and those who are suicidal as denoted from this research. Although the areas of overlap are still concerned with fear, the qualities present in the emergent spaces and development in personal and professional philosophy of being mitigate against this becoming the focus. This differs from the previous diagram of the *unceremonious pivotal encounter* whereby the nurse was concerned primarily with themselves. In this encounter the nurse was less focussed on self, and this links with Buber’s notion of ‘turning towards the other’ (Buber, 1958). See diagram 2, p.114.

Diagram 2. Ven diagram showing dominant feature of a human pivotal encounter



Chapter summary

The research has highlighted that a positive pivotal encounter includes a dialogic encounter, particularly a dialogue with an intent. It requires presentness from the nurse and the creation of a kind of space to support becoming through the construction of a crafted conversation. Incorporated into the space is the self *beyond words*, meaning the space that we occupy beyond our boundaries and the spaces we cannot see but bring to the context. The notion of fluidity and movement within a conversation and the continuous meaning making consistent with the interpretivist stance of the research refers to not reaching an end but continuously developing and moving in the context of exchange. The conversation is not preloaded or rehearsed but a natural interaction with an intention of meeting the whole person (spirit, mind and body) for genuine moments of meeting. Thus, the intention of action and the creation of a *meeting space* is a fundamental goal in *crafting conversations about suicide*.

The following chapter discusses the core category of meeting spaces in detail. It refers to shared humanness and presencing as re-occurring themes and Buber's teaching on spirituality to articulate the craft of meeting the suicidal person.

Part III

Emerging in Illuminating Space

March 2004, on a train from Varanasi, India

'This is India, anything can happen' said Shevi on the train to Jaipur. Newly married her husband accompanying her, exuding love and happiness. We had a great chat and shared food; her mother's purees and mango pickle were amazing and the sweets from Varanasi were moreish. They bought Chana Dhal and showed us wedding photos. She gave me bhindis and Sindoor powder. I thanked her warmly for her kindness and gifts. She said they weren't gifts but a sign of love.

'The body language the way that they look at you the way that they connect with you, with their eyes... it says more than the words that they use you know. It's a whole thing'

(Lillian, 234 – 235)

Chapter Eight

Meeting Spaces

This chapter focusses on the core category of *Meeting Spaces* and relevant theories. The chapter commences with reflection on Berger and Luckman's theory on the *social construction of meaning* (1967) and connects to the exploration of space and what this means in relation to nursing practice. This is relevant due to the nature of the major categories and core category. The chapter also contains discussion on spirituality. It is important to discuss this as it conveys the nature of the meeting space. Spirituality emerged as a reoccurring theme when I returned to the literature during the development of categories and themes. It weaved the findings together and represented the essence of being human, a term that was repeatedly used throughout and it is the crux of the *human pivotal encounter*.

To recap: The importance of space emerged as a theme throughout the data analysis. For those who were suicidal the three categories were; 1. *Arriving to suicide - Lost in uncharted space*, 2. *Cycling in distorted space*, 3. *Emerging in Illuminating space*. There were distinct areas of overlap with nursing students and these are categorised as; 1. *Lost in translation - Limiting space*; 2. *Experiencing dissonance - Distorted space*, and 3. *Emerging in Illuminating space*. Meaningful conversations about suicide were co-created in illuminating space in what was considered a *human pivotal encounter*. All categories sat within a fluid journey of 'arriving,' 'cycling,' and 'becoming.' The nature of continuous movement is synonymous with the continuous engagement and co-construction of meaning between individuals. A kind of space is required to support meaningful conversations about suicide. Hence, the core category, **Meeting Spaces** emerged from theoretical abstraction, as this appeared to encompass the entirety of the categories and echo the core needs of participants and hidden needs of the student nurses. This is because the experience of the encounter incorporates more than just words (as captured in the *pivotal encounter*).

It is prudent to return to the tenets of Berger and Luckman (1967) and their theory on the social construction of meaning at this juncture. According to the authors, people are generally interested in the object relations of the *immediate zone* in which they operate or the urgency of what is required here and now. Although ways of being and activity may be far removed from the *immediate zone*; the reality lived is immediate and with it is the intersubjective world shared with others. According to Berger and Luckmann, the concept of intersubjective reality acknowledges multiple realities and, with this, a common correspondence between meanings. Berger and Luckmann postulate that problems occur when doubt is introduced to challenge common meaning, whether voluntarily or involuntarily, causing a shift to 'a finite province of meaning is of a much more radical kind' (1966, p.39). In relation to this, Berger and Luckmann give examples of mystics and physicists and their inability to linguistically convey *radical* experiences due to language limitations. Crucially, and of significance to this research, is the acknowledgement of the objectification of language as grounded in everyday life. Berger and Luckman theorise that application of the language of everyday life to

describe the reality of an unconveyable experience (such as in the experience of a mystic or physicist or in this case, the suicidal person) distorts it, translating it into the 'paramount reality of everyday life' (p.40); that which is constructed in the social realm of society (or within medical discourses). We can see from the findings that this is applicable to the suicidal person, as they are aware of the translation, but their reality does not reflect the *common correspondence*, rather it is of a far more *radical kind*. On applying Bergman and Luckman's theory to the suicidal person, I envision a shift in spacial immediacy. A zone of reality that was previously remote becomes immediate reality. Undesirable encounters (such as the *unceremonious pivotal encounter*) arise when the nurse addresses the *common correspondence* and does not access their *remote space*. The latter of which is required to meet the person and discover a 'finite province of meaning.'

Applying a Buberian perspective here helps. If nurses are to support a pivotal encounter and *meet* people, they are required to access *remote space*, thus creating a meeting space where meaning can be co-created. Suicide is concerned with the formation of a meeting space and requires fully embracing the other in their otherness. Buber terms this 'I-Thou.' It requires awareness and intention of the student nurse energetically extending from self-limiting boundaries of physical self into surrounding space. It is here, in the *Meeting Space*, the spiritual borderlands, that an authentic experience can be co-created; finding meaning, validating being and engaging in meaningful conversations about suicide.

Space

Notions of time and space have occupied theological, physical and philosophical discussions. It is out-with the realms of this thesis to offer an in-depth critique of absolute and relative arguments about space and time. It is helpful though to have a cursory glance at absolute space according to Newtonian and Cartesian principles. Newton sees space as continuous and immovable and a fixed framework. Newtonian approaches are fixed within geometry and calculations, whereas Descartes refers to the *individuation* of space; emphasising the dualistic qualities of people and offering the view that individual persons can be identified 'in terms of the unique location they occupy in absolute space and time. No other person can be exactly in your or my space at a given time' (Harvey, 2005, p.12). This advocates the uniqueness of people in the space occupied (reminding us of Barker's expression; *like all other people, some other people no other person*). The definition of the meeting space in this research is reflective of social constructivist views. This is not only that concepts of space, time and place are socially constructed between people, but also that space is not fixed but universally moving, ebbing and flowing in and between people, and connected to their environments, the space they occupy and the energy they bring to it. Spaces therefore change momentarily with the flow of dialogue and meaning, and understanding is co-constructed in social exchange.

Conceptualisation of social space and spirituality

Nursing is a social activity interrelating and communicating through symbolic interaction. According

to Harvey (2005) social spaces have distinct components that influence spatial practice. Harvey purports that perceived space and the reality of how space is enacted throughout personal, private and work-related activities are paradoxical as compartmentalising space causes separation of these areas of life. Harvey argues that spaces require some cohesiveness to minimise confusion for the person, though it may not be necessarily coherent. This may be applied to the *dissonance* expressed by student nurses as relayed in this research. Students struggled to gain coherence between who they perceived themselves to be in their private world and how they perceived themselves to be in professional space as a nurse. This was conceptualised by some students as occupying two separate areas of self. However, others articulated degrees of cohesiveness between who they considered themselves to be in personal space and who they were in clinical spaces. This mirrors elements of identity (Goffman, 1959) and cohesiveness in Harre's theory (Harre, 1988). For Harre self and space are inextricably linked; the constant interplay is the person as a social being moving between places with a constructed sense of place and identity. Whereas for Lefebvre space as experienced, conceived and lived is interpreted emotionally and how space is conceptualised may affect how space is lived in and sensed (Harvey, 2005). This is of central importance when conceptualising self in the spaces we occupy. Of relevance here is how space is occupied and what space means in the enactment of humanness.

Beyond this and indicative of the research is the extension of self beyond the physical and linguistic into space shared. By being 'human' the helper holds a space where both can reside for a while, and where both helper and the suicidal person can 'meet.' It is therefore necessary to look beyond self as bound subjects and consider emanating beyond our bodily boundaries to metaphysical spaces and the importance of this as a site of interrelation. This is of significance in certain cultural practices. Reyes-Foster's ethnographic research into understanding suicide and social construction of health in Mexico uncovers important concepts of the spaces individuals occupy. In Yucatan, Mexico for example, the concept of person is characterized by a certain fluidity of boundaries (Reyes-Foster, 2013) which relate to spacial presence. Self presence extends beyond physical boundaries, turning physical space into extension of the self and therefore gives additional meaning to space. As the spiritual body extends into physical space, the equilibrium of health extends into the body social. Reyes-Foster articulates this on reflection of Hirose's work on space and time;

'If the key to bodily and spiritual health lies in a harmonic relationship between these physical extensions of the self and the individual "wrapping" represented by the human body, as described by Hirose, it follows, then, every person can extend into every other person that occupies the same place' (2013, p.13).

There cannot be a written spiritual questionnaire to uniformly assess a person's spirituality. Spirituality is the experience of deeper meaning and connectivity lived in momentary exchanges. This of course challenges the Cartesian view of the uniqueness of space, as spiritual belief states that space can be overlapped and is important for spiritual health. It suggests that the spaces individuals occupy can affect the experience of the other (I see you in your space but what emanates beyond

flesh affects me). This is an ontological shift in how we see self and how this affects meaning. For some, this is expressed as energy interchange. The nursing theorist Martha Rogers considered understanding energy fields as implicit in nursing relations; positing that man and environment interchange energy mutually and simultaneously thereby affecting the other (Rogers, 1970). Nurse theorist Jean Watson also calls for nursing the spirit or the soul (Watson, 1985). She talks about the involvement and transcendence of the roles occupied by both nurse and patient, describing union at the level of the spirit giving access to greater energy for renewal and healing. Parse (1981) and Watson (2005) refer to the essential spiritual healing role of the nurse where blurring of the personal and professional occur. This is indicative of the context described in the research as *spiritual borderlands*. Here, the nurse is facilitator and guide, reflecting humanity and supporting the exploration of meaningful conversation. Spirituality is realised *through* the interaction and created *in the space in-between*. It is here where understanding unfolds. Pesut and Thorne (2007) discuss the necessity of nurses to adopt an orientation to spirituality in practice and a reciprocal role based on humanity. It is the latter that reflects findings here. However, this stance is significantly different in expecting nurses to espouse a particular world view or ‘apply’ spiritual intervention. Nurses are part of the spiritual intervention by sharing their humanness, and understanding spaces in this way enables nurses to consider how humanness can be enacted.

This is a contentious area of debate for several reasons. When encountering a the suicidal person student nurses may be faced with spiritual endeavours as it uncovers some of who we are in each moment. Conflicting emotions may be present, and the response may be that of openness and connectedness or fear and struggle. Zen pathways point to an essential unity; a feature that was highlighted in subcategories of the research (*seeking unity, kith and kin* and *seeing shared humanness*). According to Brandon (2001) unity and a desire for holism are about an ever-present reality. It is here, where we are, that the healing takes place:

‘...at the basis of all healing, for which we are simply a vehicle, is increasing self-awareness and compassion towards others.....this asks that we recognize in our hearts our connectedness; that we surrender our different images of perfection as a deluded measure of the world and see it with honesty and love (p.38).

Ultimately, this is a quest for nurses to take time to explore spirituality, what is nourishing and what gives hope, meaning and purpose. Equally, to recognise that which is painful and imperfect gives meaning and connection in a complex expression between people. Edwards and Gilbert (2007) call for health professionals to be at ease and in touch with their own spirituality before engaging with others. Similarly, Ross (1994) explicates that nurses who are comfortable with their own beliefs are more comfortable engaging in spiritual care, further confounding the need for an underlying commitment to spirituality. There are implicit challenges with this position. For Barker and Buchannan-Barker (2004) we cannot experience the world without conceptualising it or framing ‘it’ linguistically. They argue that new concepts can be created and built into a frame of experience,

though they point out what we use instead is a readymade framework, falling to professional jargon to frame our most awkward experiences. Conversations about suicide and spirituality are, by virtue, provocative of awkward experiences but essentially required to be woven into nursing frameworks of being with others humanly. Frameworks make sense of the world, in crisis or loss, personal frameworks are fragmented and how a person makes sense of the world requires framework re-adjustment.

Barker and Buchanan-Barker (2004) purport, [the framework] of traditional psychiatry is concerned with understanding how the person ‘became’ to be like this using a historical- pathological approach, when instead we should be exploring what the process of collapse might be about. They suggest exploration of hidden meanings and what the spiritual crisis might accomplish. Likewise, for Morgan, spirituality is an ‘existential quest for meaning’ (1993, p.3) and for Thompson (2007) understanding meaning must incorporate spirituality and the role of this in the shaping of human experience. In the context of a clinical response, Karasu (1999) disregards the notion of techniques of therapy for healing, instead opting for ways of ‘being with other’ which, Barker and Buchanan-Barker add, ‘targets the spiritual centre’ (p.9). Thus, what is highlighted in the findings is the need for a *specific way of being with the person in spiritual crisis* and consideration of a complementary framework beyond a historical-pathological approach.

Meeting Spaces - Buber and dialogical spirituality

There are many theories in nursing to help gain an understanding of how people interact and how self emerges through being and relating. However, it is the philosophical anthropologist Martin Buber who offers an explanation of a dialogical spirituality, and his work emerges as complementary to the research informing this thesis. Some of Buber’s teachings have been peppered throughout the last chapters, though his work merits further discussion regarding how it fits with the conceptual framework. There are tensions in relation to the ontological stance of Buber’s work. Philips criticises the view that Buber’s work can be situated within the social constructivist domain, proffering that Buber talked about the realm of the interhuman and ‘not the relational construct of selves’ (Philips, 2011, p.30) and therefore places this within a phenomenological form of social constructionism. Whilst Cissna and Anderson (1998) refer to Buber’s contribution to *social construction* and the non-psychological aspect of self as self is discovered through living relations. Both views refer to a variation of social constructionism. Buber’s teachings are immersed with meeting and being met, a bi-directional, shared process, where each are akin to the experience. For me, this marries social constructionism with existentialism. Buber does not consider the meaning of the experience for the other separate from himself. Meaning is produced relationally according to Buber; ‘we do not find meaning lying in things nor do we put it into things, but between us and things it can happen’ (Buber, 1947, p.42).

For Buber, this is a specific kind of dialogue enacted in the I-Thou relationship where the relationship

consists of mutual openness, directness and presentness. Buber believed that human existence was about relationships, and the continued desire to meet and be met, hence ‘all real living is meeting’ (Buber, 1958 p.24-25). The need to meet and be met is consistent with both participant and students wanting to be ‘seen’, as being seen requires being met, and establishing I-Thou meets the object in its entirety. The meeting of the object moves the relation from I-It to I-Thou, from individual to person, and is termed *the site of relation*. Buber relates to dialogue as ‘sound’ and ‘gesture’ (Buber, 1947, p.5), but importantly he refers to the possibility of relation through silence. He terms this ‘communion’ (Buber, 1947, p.7) where both see the other.

Conversely, the I-It refers to the subject-object relationship. This is consistent with object relations. The I in me and the I in Thou have distance where there is no connection; we do not share a whole experience; we do not relate. This is reflective in the *unceremonious pivotal encounter* in the research findings. This is of interest to nursing and conversations about suicide because the co-creation of the I-Thou is reached through what Buber (1958) terms ‘will and grace’. Here, both parties work to create Thou, thus I-Thou is co-created, as it is what happens between two people in dialogue and it requires a continual desire for mutuality. This focus is crucial when working with suicidal people and requires the nurse to be open and present to the unfolding situation and willing to engage and see the whole person (and *courage to step over the line* into what I have termed *spiritual borderlands*). The dialogic spirituality is manifested through the common bond of spirit and spirit. For Buber this is ‘the between’, the meeting place where there is harmony between two voices; a spirit greater than the sum of these voices, will and grace, compassion and wisdom arising between (Kramer, 2012, pxxi). Buber’s concern is to open up possibilities for the humanisation of life:

‘The -I-It attitude is the charter for the scientific, the causal understanding of human beings in the world, estimation, calculation, planning, testing, replication. The I-Thou attitude is the self-understood as stepping in freedom into relation with the other’ (Berry, 1985 p.57).

Meeting spaces captures the core category of the research findings. Meeting space is symbolic in that it transcends the physical meeting space, which is of importance, to reflect a meeting space created in-between individuals. For Buber, this is dialogical spirituality [illuminating] in and between persons (Kramer, p.xix).

Long and Smyth (1998) discuss the dilemmas in caring for suicidal people when referring to Buber’s philosophy, noting initial contact phases and the paradox of construing meaning in a shared space. They comment:

‘As an I-it, the individual is considered to contain information or data wanted by the nurse, but there is no need to engage with the presence of the patient in any meaningful way. When the gathering of information becomes more important than making a connection with the presence of the patient, as nurses, we are diminished in our humanity’ (Long and Smyth 1998, p.6).

The universal tool is the nurse themselves, capable of creating or disabling opportunities to connect,

as in the unceremonious pivotal encounter. Distancing and maintaining the I-It relationship is less emotionally demanding in stressful clinical situations. The limiting and distorted spaces constructed in the research findings go some way to explain why nurses knowingly, or unknowingly, hide behind the mechanics of the risk assessment. Friedman (2002 pp. xiii) explains:

‘...I can prevent such a relationship from coming into being if I am not ready to respond or if I attempt to respond with anything less than my whole being insofar as my resources in this particular situation allows’ (2002, pp. xiii).

For Buber, dialogue is not a goal to be achieved through conscious planning but something that occurs. Dialogue is emergent and has an ephemeral quality of communication in which people are open to being altered in some way.

The nursing community’s focus on whole person care integrates body, mind and spirit. Often these terms are referred to as discreet entities that come together when addressed or applied to another person. Importantly, for Buber, addressing wholeness is multidimensional consisting of:

- Our place in the cosmos
- Our connection with destiny
- Our relation to the world
- Our understanding of the other
- Our attitude towards the mystery of life’s encounters, and
- Awareness of our own death

These arise through genuine moments of interrelated dialogue. It is a unique direction of movement generated from a response to the situation (Kramer, 2012, p.63). Importantly, addressing wholeness is influenced by one’s own spiritual understanding of where a person is in terms of his/her own life; including one’s own unique path and how one can be unified and whole. Implicit in Buber’s philosophy is that such wisdom cannot be encountered without the person engaging in dialogue or having a spiritual relation and intention of engaging with I-Thou. This reflects the research findings whereby moments of meeting were relayed and the value of this was central to what was helpful, as represented in the *pivotal encounter*. The key to understanding wholeness and self emerges from interhuman dialogue and experience of the *between*. This is termed *turning toward the other*. Buber characterised genuine, unreserved dialogue as a sacramental act, which embodies and expresses the covenant between humans and the absolute and the absolute, between the human “I” and the divine “Thou” (Kramer, 2012, xxviii).

The covenant between humans and the borderlands of spiritual exchange are key considerations in the ethics of how we prepare ourselves and our space and receive the other. Nurses are part of the spiritual intervention by sharing their humanness. This stance is significantly different in expecting nurses to espouse a particular world view or ‘apply’ a spiritual intervention, and therefore this necessitates ethical consideration.

The ethics of meeting

Inherent in conversation about suicide is the practice of turning towards the suicidal person in whole person care. Failure to turn whole heartedly traps us in individuality. The *human pivotal encounter* referred to in this research is explained as a human-to-human encounter, as the humanness expressed by the nurse creates a pivotal point for the person to turn and be reminded of their humanness.

What transpired from the research is the fundamental need for student nurses to continuously explore how they relate to suicide and what it means. Of course, in moments of meeting and exchange, the nurse gains new knowledge and experience that feeds back into the loop of experience developing spiritual understanding and growth. For theorists such as Barker, *how* nurses' approach suicidal persons are fundamental:

‘Whether or not nurses can or will address the whole person, encompassing that spiritual dimension, is clearly a moral and ethical question. Of course, as soon as we accept that people are inherently spiritual, everything changes.’
(Barker, 1999, pp.42-43).

This view, of course, is not without critics. Acceptance of a spiritual dimension does open an ethical debate about how we see and interpret the world. For others, the ethic is inherent in agreeing to partake in a professional relationship. Cooper (1988) posits that a covenantal relationship in nursing is a substantial foundation for the nursing ethic, as the relationship is based on willingness of both patient and nurse to become engaged. Cooper points out that ‘the caregiver’s initial activity within the relationship is one of responsiveness to the patients initiating presence’ (p.49). Cooper goes on to explain that this does not mean that the caregiver is indebted to the patient or is dependent on a competent or responsive patient. Rather the patient’s gift to the caregiver is ‘the mere presence of the patient’ (p.51).

Cooper relays fidelity or promise keeping as an obligation (appropriate to the context) in all nurse-patient relationships. According to Stenberg (1979) when nurses practise fidelity, they explicitly or implicitly make certain promises when entering the relationship. This includes safeguarding the person and freeing them from fear of unnecessary pain and abandonment. Cooper (1988) expands on the principle of fidelity, noting the duty of fidelity to patients is dictated by his or her previous choice to become a nurse and they must embrace the professional and the moral responsibility inherent in such a choice. Therefore, ‘fidelity by the nurse is met with trust by the patients. Such reciprocity provides the environment for caring and healing’ (p.57-58).

This is conducive with the concept of ethical immediacy (Gaddow, 1999). Ethical immediacy is concerned about enacting *good* in a relationship, that being that which is transcendent of dialogue. It could be religious, spiritual or the ethics of a profession; nevertheless, the unspoken component is something understood by both participants as their views are similar. It can be said that fidelity and ethical immediacy is an expectation of nurses from those arriving to the nurse. This is evidenced in this research. Although ethics was not explicitly voiced in the findings, *walking the navigation* line

demonstrates looking for key experiences that will facilitate certainty in sharing. The quest for ethical immediacy is another unspoken encounter contributing to the meeting space.

Cooper's extensive review of covenantal relationships in nursing advocates nurses to include fidelity as a fundamental moral principle into understanding him or herself as a nurse. The concept of fidelity chimes with findings from the research as expressed in broken fidelity when nurses do not enact the expected unspoken agreement and participants walk the navigation line of ethical uncertainty. Such careful observation and responses go beyond ethical and moral obligation for May (2000), who refers to fidelity as a way of being.

Interestingly, Cooper shares a similar view to Buber. Cooper refers to an awareness of the reciprocity of need within covenantal relationships, stating that they are mutually beneficial. A person's needs are determined as they arise. Within this relationship, nurses' needs are a recognition of the shared human condition. This extends to the research as both participants and student nurses needs were voiced. Student nurses struggled with needing to be acknowledged as humans, verifying the need for reciprocity within a nurse-patient encounter. Students also struggled with the fulfilment of this in their role, which is inherent of boundaries and subsequent distortions.

Synonymous with reciprocity is mutuality. Buber lectured extensively on the fullness of mutuality being excluded in therapeutic relations by virtue of the defining power and hierarchy in relationships. The explanation being that the situation in which the relation occurs (the seeking of help) is precisely what creates the imbalance. He does not exclude the wholeness of the experience or the intention to turn towards. The so-called power dynamic may be different but the intention to see and, Berry purports, 'that which makes therapy 'work' is precisely which imposes a normative limitation on mutuality possible' (1985, p.48). Berry however, assumes that the *therapy* is the key to whatever works between people, rather than the qualities in the relationship itself. Buber (1965) relays that the therapist or helper can accept the asymmetry of the relationship and shift how they come to it, which is different to the archetypal situation of a hierarchy. Buber calls for the other to accept the woundedness inside him/herself, as this way the hierarchy is shifted, and thus the knowledge of helper and their woundedness should not be repressed but used to acknowledge that both patient and helper are on the same *plane* (Buber, 1965). This, Berry extenuates, is the mutual confirmation of one another's humanity. It shifts the view of object-relations (I-It) encouraged in the reciprocity of a helper-patient encounter and affirms that both need each other to do 'something' together.

Therefore, for mutuality to occur, the nurse must acknowledge and accept the inequality in the relationship and strive to turn towards and experience the other as much as possible to be present and authentically engage in conversation that is not pre-directed. For Buber authentic dialogue is not preceded by formulaic questions. We do not impose ourselves on the other but encourage the story to unfold through dialogue and respond moment by moment. The asymmetry of the traditional role is absorbed through the person-person encounter, though this is momentary. Buber refers to dialogical

moments of mutuality, which are made possible by the therapist turning towards the other. If the ethic is to meet the other with good (as in Gaddow's ethical immediacy), mutuality is experienced based on a shared ethic or understanding of humanness. Layering Buber's philosophy here, shared understanding and mutuality comes with being on the same *plane*.

In their paper on negotiating professional and personal boundaries in spiritual care, Pesut and Thorne (2007) present ethical risks in relation to how nurses position themselves in a nurse-patient spiritual encounter. They argue that by adopting this position 'nurses run the risk of objectifying the spiritual, being coercive, and entering into the realms of care beyond nursing competence' (p.402). They go on to say that entering the encounter as persons with a shared humanity may lead to the experience of reciprocity. For the authors, the essence of spiritual practice is something to do to a person as opposed to an experiential exchange. Their argument stops short of explaining the difference between spirituality and religious beliefs, and religious examples are combined with spirituality throughout the paper. The authors' initial focus is that of fidelity, as an implicit (or explicit) promise to be with the presence of other. For Buber, each situation starts with self and requires responding uniquely, spontaneously and responsibly.

Pesut and Thorne (2007) express caution in nurses entering spiritual care, yet one cannot half-heartedly address this or apply it to an other as discussed so far. Taking into consideration Buber's philosophy of standing in relation to other and the explanation of the pivotal encounter (and the category of illuminating space), we begin to further understand the possibilities of spiritual exchange; 'All else lives in light' (Berry, p.66) - of having stood in relation. Berry explains that the world of things and beings are changed after one has been in relation, stating that 'one can no longer live with, use or deal with the things and beings of the world on the same objectifying way' (p.67). Individuals are affected by the meeting (this may also explain the collecting of anchors and the moment of relation explained by the participants in the research). The meeting is movement. Buber refers to returning to each situation with a renewed experience and experiences translate into being:

'Human beings exist in a continuous process of becoming, actualized in each genuine engagement which simultaneously helps others to become fully human' (Kramer, p.xxi).

Frankl (1946) recounts the moment he was given a morsel of bread in the concentration camp, and the silent exchange of eye contact during that moment expressed deep knowing and meaning. Frankl accounts spirituality with this, as the meanings which people give to the experiences in their lives. Spirituality was a human fact to Frankl as opposed to a religious fact. If the contextual needs of suicidal persons are to experience humanness, then working with suicidal persons is to be considered a spiritual activity, and we can extend from this that nursing is a spiritual activity. Furthermore, extending Peplau's' interpersonal relations and the philosophy of social constructionism, nursing is a spiritual activity whereby both parties are affected by the genuine human encounter in a process of continuously becoming.

It is this that reminds me of Mary Beards' retelling of the story of the Caves of Ajanta in North West India, apparently rediscovered in 1819 by Herringham, an artist suffragist intrigued by stories of an ancient Buddhist site. Arriving to find floor-to-ceiling paintings depicting Buddha in search of enlightenment, all in a state of decay with many details lost, Herringham and her team went about painstakingly tracing the ancient images to preserve them. Working by lamp light, the result was creation of beautiful coloured plates replicating the art and preserving them as part of world heritage. However, Beard emphasises that Herringham 'radically and problematically re-interpreted these paintings' (2018, p.125). She saw them as an Indian version of Italian Renaissance art and referred to them as a 'picture gallery' as the art was representative of the paintings but the context and meaning of the paintings were lost to her. Beard extenuates that context here is crucial, and that one could not be a passive consumer of the images as it was required to have an active interpretation, as the complexity and fragmented narrative was purposeful, representing inconsistencies, open-endedness and contradictions. The original artists were making the *viewers do religious work*; working to identify, find and re-find stories of the Buddha (p.128). The lack of light was significant, enacting a metaphor for searching for light and faith in darkness. This story is pertinent in engaging in conversations about suicide, as how we *see* is crucial. To avoid the 'radical and problematic reinterpretation' of the person, we must be mindful of the context in which the person comes to us and from which we operate, and the symbolic power of this. Biomedical discourse may represent a certain type of 'picture', but it is the context and meaning that require unearthing. I think of the metaphorical dance between nurse and person, both actively engaged in spiritual work, identifying finding and reshaping meaning in personal stories that are perhaps fragmented, lost in the dark with the nurse providing illumination by sharing their humanity.

Chapter summary

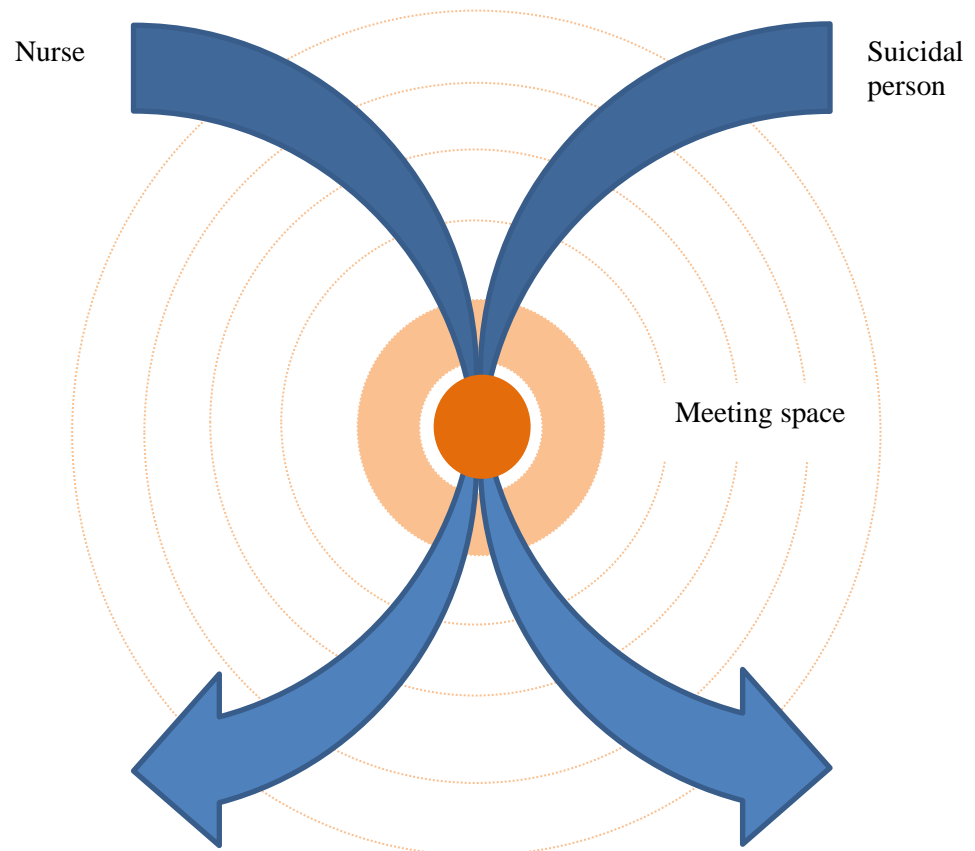
Charmaz (2014) reminds us that people react in relation to how they view the situation and that, in turn, our actions and those of others affect situations and may alter our interpretation of the current context, past understanding or what may come. The findings of the research emphasise the importance of being met as a human in a particular space. For this to be realised, nurses are required to acknowledge their woundedness, intend to *meet* the person and, with this, be open to being met in a mutual encounter. For this to happen, a way of *being and seeing* and a willingness for dialogue is needed, all of which requires one to navigate moment by moment as the situation unfolds.

Chapter Nine

Proposing a Framework for Conversations about Suicide in Nurse Education

It is prudent at this juncture to summarise the research findings and extend the discussion to a framework for nurse education. The importance of space emerged as a theme throughout the data analysis. The core category was Meeting Spaces. Meaningful conversations about suicide were co-created in illuminating space in what was considered a human pivotal encounter. A specific kind of space was required to support meaningful conversations about suicide, as the experience of the encounter incorporates more than just words. Reflecting on Buber's teachings on spirituality, the formation of a meeting space requires fully embracing the other with awareness and intention, energetically extending boundaries of physical self into the surrounding space. It is here, in the space in between, the borderlands, that an authentic experience can be co-created.

Diagram 3. Summary of the research -Human pivotal encounter



It has been discussed so far that how we ‘see’ is crucial to how a situation is approached. Earlier in chapter eight, I highlighted the need for a specific way of being with the person in spiritual crisis and proposed consideration of a complementary framework beyond a historical-pathological approach. At the close of chapter eight I argued: if the contextual needs of suicidal persons are to experience humanness, then working with suicidal persons is to be considered a spiritual activity, and I extended from this that nursing is a spiritual activity. Collectively, these discussions support a shift in thinking in how student nurses see and approach the suicidal person. Couched in this is an ethical dilemma concerning what nurses accept people to be and, with this, what they consider themselves to be. Considering the argument for nursing as a spiritual practice, and the meeting of a suicidal person as a spiritual activity, then it is prudent to conclude that there is a need to accept self as spiritual to be able to accept others. Buber described genuine conversation as ‘acceptance of otherness’ (1965b, p.69). The research refers to seeing shared humaneness in illuminating spaces and to be on the same plane, while Buber argues one must accept one’s own woundedness.

The teachings of Hasidic spirituality as relayed by Buber share core principles of Zen Buddhism in that real awakening takes place in a living response to being challenged to one’s core being (Kramer, 2012). Suicide and the extensive questions and uncertainties it raises can be considered a core challenge, especially related to life and death and the religious, spiritual and ethical uncertainties related to it. It is the experience of presentness, or the here and now of dialogical exchange that Buber refers to as genuine living. For Buber, as for Buddhism, being here now, fully present to what is occurring is core to being.

Buber relays Hasidic teachings as stories, not as philosophies or theological discourses. As interpreted by Kramer (2012), the focus of each spiritual teaching is concerned less with *what* is learned than with *how* what one learns is lived. Buber’s teachings are Hasidic in nature and refer to the divine but not the absolute divine. Buber’s philosophy is not absolutist. For these reasons, and for accessibility, I have removed references to God. Like Buddhism, finding one’s *how* in the world and therefore being with others in genuine relationship is key. Buber extends respect to Tao teachings and acknowledges spiritual and religious diversity, referring to each person finding their own way of genuinely being with other through spiritual meeting.

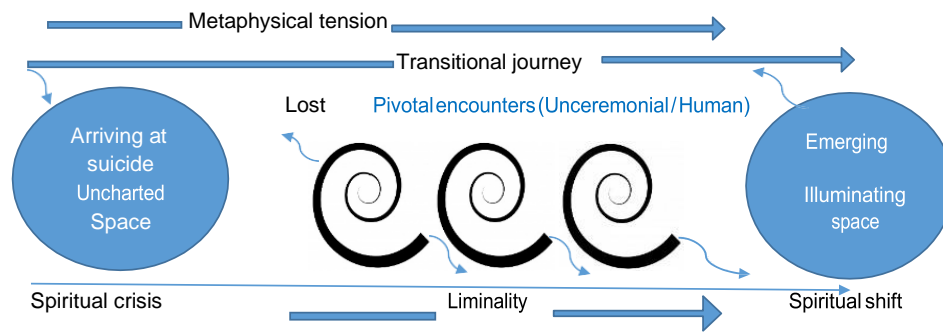
The wisdom contained in Buber’s spiritual teachings is applicable to crafting conversations about suicide in nurse education and the research findings here complement many of the principles within. According to Buberian philosophy, this is turning toward the person and requires spiritual preparation. According to the findings, the subject of suicide is not an isolated problem. It is the existential impact and location of this that requires exploration. Locating suicide in wholeness and the wider spaces that this is attributed to may provide an important educational basis for suicide in a nursing context. According to Buberian philosophy and synonymous with the methodology in this research, movement is important; willingness for dialogue requires one to navigate moment by

moment (Friedman, 2002).

Revisiting the research finding in more detail

Below is a condensed journey overview (See chapter seven for a full account and discussion). A summary of findings and related discussions are presented to create a recap for the developing framework:

Figure 10. *Journey overview for participants*



Major categories: *Arriving to suicide - lost in uncharted space*; *Cycling in distorted space* and *Emerging in illuminating space* (for participants). Major categories for student nurses are similar (*Lost in translation - limiting spaces*; *Experiencing dissonance - distorted spaces* and *Emerging in illuminating spaces*).

For participants: *Arriving at suicide – lost in uncharted space*. Harboring of pain may include untold stories of why. Suicide is uncharted ground and the person is experiencing a spiritual crisis. New perspectives of self are encountered, and the experience can be disorientating and inarticulable. The person may be acting with naivety and with ambivalence given the dichotomous worlds they occupy.

For student nurses: *Limiting spaces*. Some students occupied limiting spaces. The intention to connect is limited by *fear* of the student nurse and is influenced by properties discussed in the category of *limiting spaces* (related to *self- belief* and *sub-categorised into emotional and knowledge limitations*). *Fear of the unknown, consequences of actions and their own vulnerability* is a limiting factor. Accepting otherness and being in a conducive space requires the student nurse to explore and accept where they are in relation to suicide before they enter a situation of asking about suicide and being with all that this may bring. It is therefore necessary, as a starting point, to address these areas. With this is the ethical dilemma of accepting people and self as spiritual and continuously discovering what that means.

For participants: *Cycling in – distorted space*: the logic of protecting others by not sharing their personal story whilst legitimising suicide as the best way forward. This juxtaposition is explained by the distorted thinking that the pain they bring to others will finish soon after they die. Equally, the person ‘shouts’ their internal pain, although invitations to speak can be subtle or obscure. The pain is

silent to others who do not speak the language of suicide. Collecting anchors and pivotal encounters are important during cycling.

For students: *limiting spaces - lost in translation*: Predominant is *establishment of belief* in the suicidal person by referring to medical frameworks and limiting language for suicide, including preoccupation with *risk and intent*. The person is also unseen as they are further fragmented by the nurse's *personal and cultural beliefs*. There is a complete disconnection between the suicidal person's need and the nurse's focus. Space is distorted as the person is misrepresented in discourse.

Both participant and student nurse: Pivotal Encounter: The person desperately wants to be seen, '*see me*'. There are expectations such as the nurse's ability to pick up on pain ('we expect you to be mind readers'), validation of feelings and meeting of needs such as enacting a caring philosophy to suicide, an authenticity, and facilitating conversations to uncover '*why*' whilst allowing the person to remain in control of decisions. Value is experienced through space and the craft of the conversation as opposed to being led via prescribed questions. '*Human encounters*' are meaningful; the person has a full experience of being seen and met. Conversely '*unceremonious encounters*' are unmeaningful and spark further disassembly and distortion. The experience of stigma, institutional and personal labelling is unrecognisable to the person and what they are experiencing. It is a different language. *Walking the navigation line* is enacted in the interaction with the nurse, and searches for something shared and understood, and through developing trust whilst the nurse struggles with *personal and professional self*.

For students: *experiencing dissonance - space*: there is dissonance regarding professional self and personal self, seeing self before seeing other, and also wanting to be seen. This coupled with the above supports *walking the navigation line* as the student traverses' elements of *role expectation, ethics, consequences of actions*, etc.

For participants: *emerging in illuminating space*. This denotes a spiritual shift. There is gained knowledge and wisdom, being at the edges of self, knowing what works, gaining hindsight and developing a different relationship with suicide. *Seeking unity* and sharing *wisdom* are also located here.

For students: *emerging in illuminating space*: Those who had already arrived in *illuminating space* were able to see beyond self to *seeing shared humanness*. They were comfortable with their philosophy and where to locate themselves in relation to the needs of suicidal people. Others are with dissonance, struggling to understand how to be with self and the suicidal person. *Metaphysical tension* – the person enters the world of suicide, which is new and incomprehensible. Tension occurs as the person struggles to understand their own meaning and place in the world, this is further challenged by relational encounters. They do not understand the language used to describe them as it is juxtaposed to their experience. It is a metaphysical struggle described in an empirical context. This is exemplified in diagnosis, assessment questions, reactions from others, and power struggles.

Liminality – the space in between becoming suicidal, creating a different relationship with suicide and being in the world, the person is changed positively due to the experience.

It is clear to see the juxtaposition of nurse and suicidal person in areas throughout the journey. In relation to shared spaces, nursing is based in dialogic interaction *in* and *through* interpersonal relationships with the *intention* of connecting with another human. Intention to communicate and connect precedes action. It is developed from the research findings that a *human pivotal encounter* is required, via creation of a space where each person can be met in the *meeting space*. Intention can be limited by how the person sees, and the limitations and distortions presented above. What follows is a presentation of a theoretical framework combining the research findings with underlying principles of symbolic interactionism to facilitate being with self and suicidal others. It is explicit from the preceding discussion that this is the crucial starting point for *crafting conversations about suicide in nurse education*.

Constructing a framework – crafting conversations about suicide in nurse education

It is perhaps prudent to point out that there is a plethora of definitions of spirituality in the academic and nursing literature. I offer no definition of spirituality per se, or a descriptive framework purporting to describe a way of being. Swinton (2006) raises a significant point referring to definitions as narrow, creating boundaries around what nurses think spirituality and what the subsequent care should be. This framework supports wider understanding and ability for constant review and change of one's own personal spiritual understanding by asking where am I (in relation to my philosophy, in relation to suicide)? The framework proposed combines these research findings with Buber's philosophy on dialogical spirituality and the tenets of symbolic interactionism. The framework is a shift from psychiatric discourse into spiritual and existential domains as an initial starting point of co-creating conversations about suicide. Inherent are ethical and moral considerations synonymous with adopting such a position.

The Meeting Spaces Framework can be used as an educational tool to facilitate conversations about suicide in nurse education. The model is designed to be referred to on an ongoing basis and requires preliminary exploration and practice by the student and the educator. The core of the model is interhuman relations and the co-construction of meaning in meeting spaces. The construction of meaning is whole person to whole person. The educator should be able to know where they are in relation to the matter of suicide.

Underpinning principles

The theoretical framework supports adopting a position, meaning a way of being with those who are suicidal. The position proposed for adoption is based on Buber's six spiritual teachings (see summary of Buber's teachings in Box 1). It incorporates theory from the research and spiritual elements discussed in the previous chapter. This has been expanded to create a nursing position, including

findings from the research and tenets of symbolic interactionism (See Box 2).

Box 1. *Applying Buber's spiritual teachings to conversations about suicide in nurse education. Adapted from Kramer, (2012, p. xxxvii)*

1. Heart searching

Decisive heart searching – the beginning of the human way, responding to the question: Where am I [on this human way]? Which is designed to deconstruct your system of hideouts and the help you know from where you came, where you are going, and to whom you will have to render accounts.

2. Your way

Every person's unique task is to get in touch with life-valuing relationships with others and that which connects you in your own way with your whole being.

3. Resolution

Part of spiritual practice is necessary to seek resolution by refocusing on the goal and by remaining wholly open to whatever addresses you.

4. Beginning with oneself

To advance spiritually, you are required to begin with your deeper self, by taking full responsibly for any conflict situations by harmonizing your thought, speech and action, and by saying what you mean and doing what you say.

5. Turning towards others

Practicing genuine turning, from self orientation toward the orientation of otherness of the other. According to Buber, this renews you from within and deepens your connection with the world.

6. Standing here

Fulfilment and discovering purpose, letting that which universally connects guide and maintain interaction with the world.

1. Heart searching

Nursing is an interhuman practice, multifaceted and complex, incorporating the whole spiritual being. In order to *meet* other, the nurse is required to explore the meaning of spirituality for themselves, the space they occupy, the space they hide, the source of connection and who they answer to. The nurse needs to be aware of their own limitations and strengths in relation to responding to suicidal persons or asking about suicide as we act on the basis of the meaning things have.

2. Your own way

Nursing addresses humanity in all of its guises. Relationships are living, and it is through social connectivity and co-construction of dialogue with others that we interpret the meaning of life. Utilising that which connects you creates the intention to interact with others wholly, honouring the other and what they bring to the shared space.

3. Seeking resolution

Nursing requires self-awareness. Increasing self-awareness involves seeking resolve to that which causes conflict and pain. Buber's teachings relay that resolution *precedes* spiritual practice. This interpretation acknowledges the first three stages as spiritual practice and that resolution is part of spiritual practice. Resolution may be ongoing or reignited, given the contexts that arise and symbolic interpretation of conversation constructed with others.

4. Beginning with yourself

Nursing and interhuman relationships requires transparency, honesty and trustworthiness both with self and with others. It requires acknowledging vulnerability. Recognising your own vulnerability is a strength in human connection and can mirror that of others. You are responsible for what you bring to the space, both verbally and energetically, therefore developing understanding of conflict areas (such as suicide) and the meaning of this to practice is fundamental before you can turn to the other and engage in genuine conversation.

5. Turning towards the other

Nursing requires accepting the other in their mere presence, as the 'otherness of the other.' The nurse's intention is to seek shared humanness and to be open to renewal of meaning through what is co-constructed in the expanding interactive context. In the case of suicide, spirituality comes to the forefront of whole person care, as intention precedes action and the nurse is mindful to intend to *meet* the other. The nurse's conflict or fear of suicide will be affected due to the co-construction of meaning and interaction with the other through the process of genuine dialogue.

6. Standing here

Nursing requires the extension of hope and letting that which universally connects guide and maintain interaction with the world. In the case of conversations about suicide, the nurse's authentic occupation of space and presence can provide illumination in the interhuman relation.

The table below combines the underpinning symbolic interactionist principles discussed in chapter five with Buber's teaching of spirituality and the research findings to demonstrate the basis of the *Meeting Spaces Framework*. Concepts are grouped left to right.

Table 6. *Premises of Symbolic Interactionism, tenets of Buber's spirituality and categories of Meeting Spaces*

Premises of SI	Buber's spirituality	Nursing students	Participants
Human beings act towards things based on the meanings the things have for them	Critical appraisal of the starting position of engaging with suicidal others, current practice and beliefs. What is your starting position?	Limiting Spaces <i>knowledge Distorted space Conflict Establishing belief</i>	Lost in uncharted space <i>Harbouring pain</i>
The meaning of such things arises out of, the social interaction one has with one's fellows	1. Heart searching 2. Your own way 3. Resolution 4. Starting with yourself 5. Turning towards the other 6. Standing where you are	Walking navigation line Unceremonious pivotal encounter (I-it)	Cycling -distorted space(I-it) Lost in translation <i>Being a body/risk Branding Untold stories Power and control Inauthenticity</i>
These meanings are handled in, and modified through, an interpretative process used by the person in dealing with the things he encounters		Illuminating space Seeing shared humanness Meeting others Human pivotal encounter (I -thou)	Illuminating Space Presencing <i>space and time Authentic care Freedom Seeing me</i> Emerging Seeing other <i>Anchorage Seeking kinship Valuing wisdom</i>
Blumer 1969, p.2			

The Meeting Space Framework; crafting conversations about suicide in pre-registration nurse education integrating Buber's spirituality.

The connection between each area is observable and falls into distinct patterns, as seen above. The framework is based on fundamental aspects of this research. It requires personal exploration by student nurses about the subject of suicide. It explores the myths and focus of risk before moving to higher elements of discussion and exploration that supports the development of meeting spaces

through *human pivotal encounters* (See figure 13). The pyramid can be used to facilitate class- based discussions of conversations about suicide. As the subject matter is deep and involves exploration of spiritual subjects, class-based discussion may be attempted in three phases, correlating to the key code. A template of the triangle can be used by students individually as a learning and reflective tool to map where they are at any given point. It is acknowledged that these change and evolve continuously through conversation as meaning is interpreted and evolutionary.

The circle encompassing the triangle represents the fluidity and ongoing movement throughout meeting spaces and the construction of meaning. It also represents Buber's primary questioning of asking oneself, where am I? on the left as a basis of opening conversation and in preliminary exploration of one's own spirituality. It asks the student to continuously assess where they are in relation to addressing suicide through whole person care. The importance of the circle sustains the path of meeting other and engaging in a human pivotal encounter and is *a way of being* rather than a goal. The relational encounters will be universally different each time. The student may not always experience positive outcomes, as the circle and direction of travel encompass the unknowingness, which cannot be accounted for.

The framework has a spiritual focus, as the intention is to move from object relation conversation (I-It) to whole person dialogue (I-Thou). This direction works towards a human pivotal encounter, emerging in the meeting space. The meeting space is constructed through the achievement of dialogue and being present with the whole self.

It is noted that the subject of suicide and areas for exploration and discussion may appear contentious in the first instance. Students may be concerned about voicing feelings other than those expected of them in their role. It is imperative that honesty is encouraged, and a safe environment created, to allow students to acknowledge their human response. The nature of personal inquiry can be illuminating and distorting.

Caveats

What the framework is not

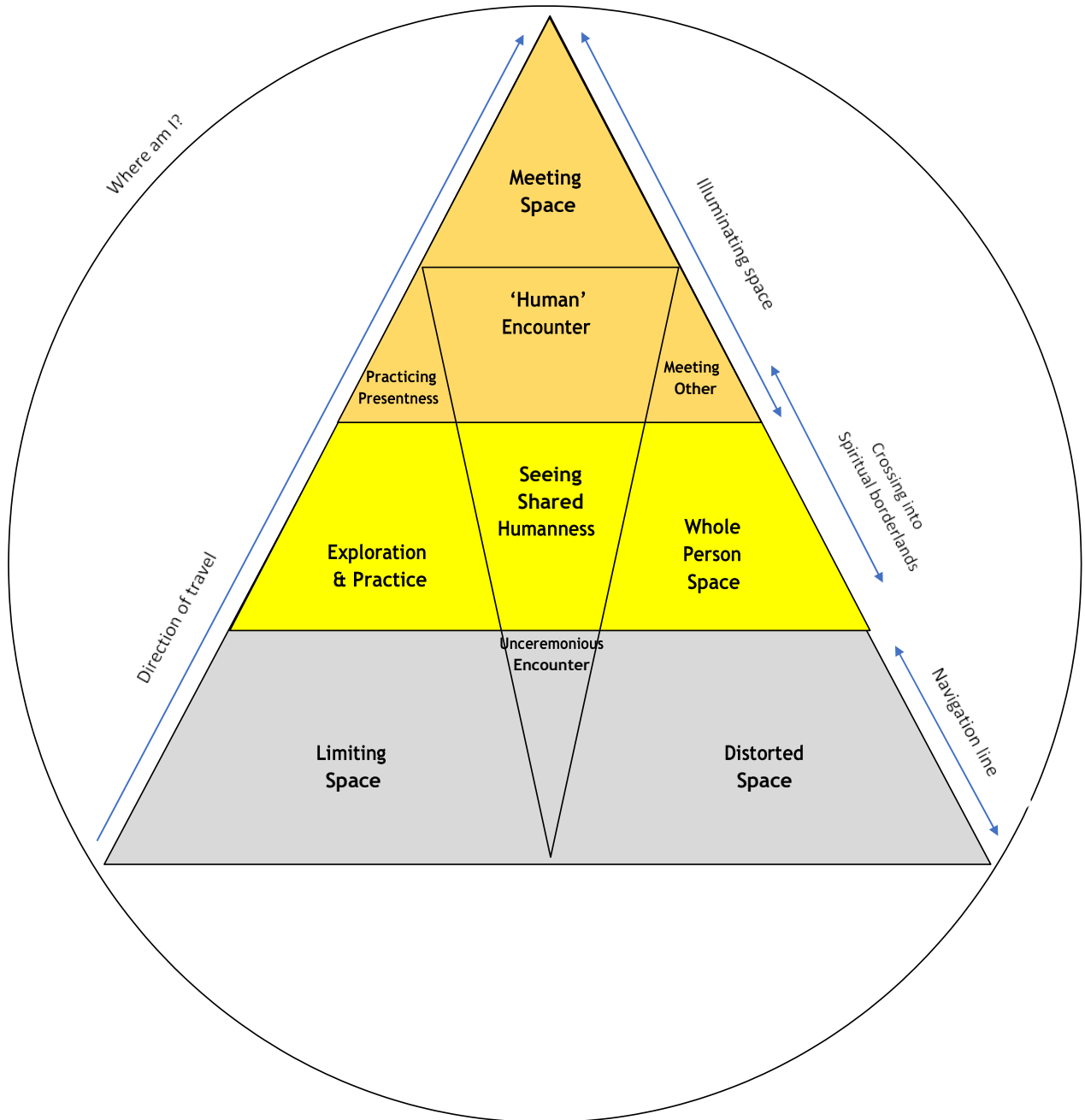
The framework is not a prescriptive guide. It does not provide orderly questions to ask in a conversation about suicide. It is a framework conducive with the emerging needs of suicidal persons. It is complementary of Health Education England and Public Health England strategic workforce development plans with an emphasis on whole person care and co-produced care, driven by patient, rather than professional, need.

Emergency care

It is worth explicitly stating that in any case of harm, stability of bodily systems is of course imperative. This does not detract from the focus of whole person space, whereby parties genuinely meet the other and hold the space authentically whilst attending to emergency care.

Figure 11. The Meeting Space Framework; crafting conversations about suicide in preregistration nurse education integrating Buber's teachings on spirituality.

To be used in conjunction with underpinning principles in Box 1 and 2. Key follows on p.137.





Limiting spaces

The educator to explore with students directly or can be student-directed study in preparation for discussion at a follow up seminar.

This section is about raising awareness of current beliefs and practice, and critically questioning this.

- (a) **Limited self-belief** in responding to a suicidal person. These may present as *emotional limitations*, limitations *of knowledge* and *harbouring fear* of the subject of suicide. *Vulnerability* is a key feature where exploration of the *consequences of actions* and acknowledging one's own vulnerability in the context of conversations about suicide is foundational to moving up the triangle. This domain is head-led.
- (b) **Lost in translation.** Activities that lose the person and do not allow them to be seen. This is not representative of whole person care. The initial response and approach is that of *medicalising suicide*, and therefore the person, and establishing *risk and intent* in the first instance. Such discussions are not to deny the medial construct of suicide but to understand the location of it as limiting and unrepresentative of whole person care. The person's perspective of lethality, and the story of why, is key. Seeing and meeting will allow the information to be shared more readily and consensus gained to involve others. This section merits critical debate about how the student nurse *sees*.

Responding to suicidal persons in this domain reflects the **I-It** attitude - the focus of the scientific and causal understanding of human beings in the world, head-led. The basis is objectifying, describing and measuring. Discussions of high and low risk and intent are objective and meaningless to the person. The I-it operates in objective relations. It occupies a small space in relation to the overall meeting space encounter and denies an I-Thou experience of a human pivotal encounter.

Personal explanations include exploration of cultural and personal beliefs, influences of family and friends, and life experiences.

Unceremonious encounter. Sharing of elements related to unhelpful pivotal encounters as co-created with those who have been suicidal and in receipt of nursing intervention. Use of examples and stories can enhance this.

Distorted space

Exploration of areas of discord in relation to;

(a) **Professional self** - this features dissonance, as the conflict of personal self and professional self. Professional self issues may include *expectations*, *role restriction* and *ethical and moral* tension regarding the right to live and die coupled with personal spiritual or religious views. See Jackson and Stevenson (2000), 'the three me's.'

(b) **Personal self** – acknowledging feelings of being with suicide and those who are suicidal. Exploring conflict of what the students are thinking and feeling. Explore the need to be seen as a person, which may be coupled with vulnerability. There may be conflicts between responding as 'me' and responding as a nurse because it is expected. This core area links with limiting spaces. The **I-It** in operation here is concerned with 'me-ness' as opposed to 'otherness.'



Illuminating space

Exploration and practice

To be used in conjunction with Spiritual Framework in boxes 1 and 2 (Points 1-3, heart searching, your own way and resolution).

Heart searching using Buber's preliminary practice features here to create *heart searching* responses to the existential question, where am I? Aligning head, heart mind body and spirit with each other. Understanding where we are in any moment. Shift from knowing, describing and objectifying to affirming answering and relating (Kramer, 2012, p.5). Preliminary practice moves the student nurse towards practicing presentness and meeting the other. The emphasis is on finding *your own way*, relating to the life path and gaining *resolution* with self. Resolution is concerned with the commitment to address conflict within oneself.

Whole person space

This relates to the moral and ethical question of nurses embracing a spiritual dimension to caring or embracing the other as a spiritual being. In the case of the framework, this is an essential basis and focus for the interhuman relation. It includes the exploration of the spaces we inhabit, spatial presence, energy and spiritual borderlands. It considers the extension of self beyond the physical self and the student nurses' relationship with that.

For Buber, wholeness is multidimensional. Buber's list can be used to guide exploration and discussion and construct meaning.

- Our place in the cosmos

- Our connection with destiny
- Our relation to the world
- Our understanding of the other
- Our attitude towards the mystery of life's encounters, and
- Awareness of our own death

Seeing shared humanness

This is approached by addressing the above and the areas in the base level of the triangle to support the *establishment of personal meaning*. Seeing shared humanness is related to seeing others as human, moving to I-Thou and away from objective relations. This is about *embodying caring values* and relaying them energetically, as opposed to a rhetoric that is unfelt. The starting point is accepting the presence of the person and understanding the ethical and moral foundations of the nursing role. The intention is to be open and truthful, sharing intention and seeking support when required. Seeing shared humanness warrants discussion and exploration of *will and courage* to meet the other, in order to *cross the line* from objective boundaries into spiritual borderlands to a meeting place. This space is the platform for practicing presentness.



Illuminating Space

Practicing presencing

To be used in conjunction with the Spiritual Framework in boxes 1 and 2 and points 4-6 (starting with oneself, turning towards the other and standing here).

For Buber this begins with oneself and relates to the whole person as discussed above. The preliminary exploration and practice set the foundation for seeking peace in your own space with suicide and related existential concepts (Buber's list above). **I-Thou**, turning towards the other, is the intention. For Buber the person seeks interrelation and realizes contact with others.

Meeting Others

Seeing humanness: by seeing the person and not the individual, students are establishing an understanding of their personal and professional philosophy and are supported to share human caring values. This includes exploration of professional boundaries and what this means, and the *will and courage* to cross into spiritual borderlands. It is a place of being present, as another human being, thus imbedding the qualities of *caring values* in the *human encounter* (human pivotal encounter sees related diagram on page). Meeting other and *seeing shared humanness* is an assumed ability that nurses can and will do this. This is not the case and requires self-awareness, developments and support and a different way of seeing.

Straughair, (2016) developed a model for compassion for humanising nursing care in care contexts. One component highlighted the student nurse starting with a *compassionate self*. Straughair purports that this is essential for

‘motivating nurses to connect with the individuals they are caring for and implement action for compassion through humanising approaches to nursing care’ (p.303).

It also advocates that humanising approaches to care are supported in educational contexts for nurse education, extenuating the importance of personal narrative and authentic learning experience to ‘provide a platform from which to build nursing care approaches’ (p.304). *The Meeting Space Framework - crafting conversations about suicide* is an example of a humanising approach to care in a dialogical context.

Chapter summary

The framework proposed is constructed as a result of the findings from the research contained in this thesis. Buber’s spiritual teachings are contained within as discovered through the evolution of the research and as fitting with the conceptual framework of the research. Inherent are research findings from related literature. The categories constructed with participants are a fundamental aspect of the education and excerpts from interviews can be used to illustrate pivotal encounters in relational contexts. The use of personal stories of experience creates an authentic translation of the framework. It is acknowledged that implementation of such approaches is loaded with challenges. These notable challenges are discussed in the next chapter along with reflections on the research and further considerations for nurse education, practice, policy and research.

It is perhaps prudent to point out that there is a plethora of definitions of spirituality in the academic and nursing literature. I offer no definition of spirituality per se or a descriptive framework purporting to describe a way of being. Swinton (2006) raises a significant point referring to definitions as narrow and creating boundaries around what nurses think spirituality and the subsequent care should be. This framework supports wider understanding and ability for constant review and change of one’s own personal spiritual understanding by asking where am I (in relation to my philosophy, in relation to suicide)? The framework proposed combines these research findings with Buber’s philosophy on dialogical spirituality and the tenets of symbolic interactionism. The framework is a shift from psychiatric discourse into spiritual and existential domains as an initial starting point of co-creating conversations about suicide. Inherent are ethical and moral considerations synonymous with adopting such a position.

The meeting spaces framework can be used as an educational tool to facilitate conversations about suicide in nurse education. The model is designed to be referred to on an ongoing basis and requires preliminary exploration and practice by the student and the educator. The core of the model is

interhuman relations and the co-construction of meaning in meeting spaces. The construction of meaning is whole person to whole person. The educator should be able to know where they are in relation to the matter of suicide.

Chapter Ten

Conclusion - Reflecting Back, Moving Forward

The aim of the research study as presented at the beginning of this research journey was to explore what was needed to have conversations about suicide, from the perspective of those who had been suicidal and student nurses. I have presented a *meeting space framework* representative of the grounded theory developed from the research. The following is an exploration of the credibility and applicability of this framework to nurse education and practice, research and policy.

Reflecting Back

Limitations, credibility and trustworthiness of the research

In order to reflect upon the credibility, dependability and trustworthiness of the research, it is helpful to recap on interpretivist research (underpinned by the theoretical framework of symbolic interactionism and social constructionism). Integral to this position is the inseparability of myself from the process and the co-construction of the data and subsequent grounded theory. The constructivist grounded theory approach adopted (Charmaz, 2010, 2014) is also drawn from the theoretical framework of symbolic interactionism and social constructionism, thereby providing the methodological vehicle for the research. The generation of new knowledge (grounded theory) is representative of the multiple realities embedded in the co-construction of data with the knowledge and experience of the researcher (in the spirit of transparency, Appendix 3 captures related concurrent activity during the process of the research). Charmaz views actions 1-5 as evidence of a grounded theory study (Charmaz, 2014, p.15).

1. Conduct data collection and analysis simultaneously in an iterative process
2. Analyse actions and processes rather than themes and structures
3. Use comparative methods
4. Draw on data in support of developing new conceptual categories
5. Develop inductive abstract analytic categories through systematic data analysis
6. Emphasise theory construction rather than description of application of current theories
7. Engage in theoretical sampling
8. Search for variation in the studied categories or process
9. Pursue developing a category rather than covering a specific empirical topic (Charmaz, 2010a, p.11)

The first five points were followed throughout data analysis and towards the construction of the grounded theory. This is discussed throughout chapter six. Examples of decision making, and an audit trial, are available throughout Appendix 2. Theory construction is demonstrated in Appendix 2 and in chapters eight and nine, as stipulated in point six. Regarding point seven, there are

limitations following the principles of theoretical sampling. Admittedly, there is evidence of convenience sampling as the students accessed for theoretical sampling were within one higher education institution and participants were accessed from one organisation (Launchpad). This was noted earlier. Theoretical sampling led me to year-three students who had exposure to education of suicide and were also more likely to have had exposure to suicidal people in practice. The nature of the theoretical sampling was such that it was necessary to convene a focus group to see if the emerging themes and categories were concurrent across the three years. Invariably they were. There were some notable agreements with students in years 1 and 2, and thus time in education did not appear to offer a significant difference to the emerging categories. The mature students (age bracket 25 and above) offered whole person approaches, but equally two of the younger students in year 1 shared these views, showing that maturity of age was not necessarily a precursor for acting within spiritual borderlands. The limitations of theoretical sampling were influenced by the parameters agreed in ethical approval, my own part-time post-graduate status and the timescale for completion of the research.

Students in years one and two had not received education in suicide at university at the point of involvement in focus groups. There were limited contributions from other fields of nursing: two were adult students and the rest consisted of mental health student nurses. This was addressed during sampling. Emails for requests for student volunteers were sent via programme leads and I attended classes in person. In some way, this reflects the general picture from the literature regarding fear of talking about suicide and the limitations of expected intervention as per job role.

Semi-structured interviews may be considered limiting, though the flexibility of this allowed enough room for the interviews to flow and resulted in data collection that was rich. Participants were generous with their time and information. Member checking is recognised as a reliable technique for establishing trustworthiness (Guba and Lincoln, 1989). Clarification prompts in interviews and focus groups were carried out. Reflexive notes, memos and field notes accounted for interpretations throughout the process. Examples of these are available as directed earlier in Appendix 2.

Constructivist grounded theory is considered not generalisable to the wider population due to its epistemological and ontological basis. Ontologically, the notion of multiple realities is supported, asserting Mead's perspective that 'many truths can exist together'. Epistemologically, a subjectivist position is adopted to support the co-construction of knowledge and rendering the possibility of multiple 'truths.' The 'ontological loop' is of significance here. From this stance, an extreme view would be that 'truth' is therefore unattainable as there are multiple view-points and therefore the research is a construction. This extreme suggests the adoption of a relativist stance. Although I do not follow this path, I do acknowledge that the research contained in this thesis is influenced by personal experiences, interpretations and reflections and I align it to the contribution to the argument by Williams. Williams acknowledges that interpretative research is not generalisable to the wider population and, as such, calls for 'moderatum generality' whereby aspects of research can be seen to

be instances of broader recognisable features demonstrating elements of cultural consistency (2000, p.130). Research conducted in social groups can resonate with others that share historical and contextual similarities. Given this perspective, findings informing this thesis, and laterally the *meeting space framework*, offer propositional generality.

Moving Forward

Translation of research findings to education and practice

The meeting space framework; crafting conversations about suicide, could be introduced to students in year 1 or 2 of the curriculum, ensuring time to sequentially embed learning and practice. Scaffolding learning and allowing students to return to the framework to reflect on knowledge and skill development is key to self-awareness and understanding *where am I* (in relation to other)?

The meeting space framework is flexible to different learning styles (Kolb, 1984). It can be presented in detail, explored in seminars, presented in templates for interactive and systematic learning and students can work on the framework in private beyond the classroom discussions. It lends itself to independent discovery, prepared exercises and interactivity. It can also translate into clinical practice; linking theoretical, spiritual and practical perspectives to the clinical context. Students are required to collect evidence as part of completing competencies in clinical practice. Referring to the framework and checking ‘*where am I?*’ in relation to traveling towards a *human pivotal encounter* may serve as a reminder of the intent to connect humanly with suicidal people. This is also critical for reflective practice to reinforce learning. In the spirit of engagement with patients and transparency, the student could engage with the person afterwards and when appropriate and ascertain ‘*where they are*’ in relation to the framework. The aim to ascertain feedback asking, how did you experience this? And importantly, did *I see you*? Not only does this provide a basis for transparent discussion, it challenges the archetypal hierarchal approach to relationships and embeds the human-to-human dynamic (as discussed on page 122). Hubble, et al. (1999) emphasise the common factors that indicate successful outcomes for clients seeking help. They identify that the most powerful indicator is the therapist adopting a change focus, for the therapist to create ‘a context in which new or different perspectives, behaviours, or experiences can be explored’ (p.409). Relationship factors are identified as the second greatest contributor to change. *The meeting space framework* supports both of these observations. Spaces are important for supervisory processes too. Supervision supports space for change and building of relationships. The meeting space framework lends itself to the supervision processes, aligning with skill development in the practice arena along with enhancing ways of knowing by reflecting on experience (Carper, 1978; Johns, 1995).

Occupying a safer space with suicide allowed students to offer a human response, as otherwise the first response is that of the discourse which defines the person in medical terms. The base of the pyramid supports discussions around this and the knowledge to be collated, but not in the first instance. The first instance is to intend to meet the person and prepare the space. With this in mind, it may be

beneficial to extend the notions of alternative discourses throughout the nursing curriculum, presenting legitimate choice to the student given the sensitivities of the situation.

Directions for research

Further research is required to investigate *the meeting space framework; crafting conversations about suicide*. The constructivist nature of the research is such that it is propositional and context-specific. The suggested framework and implementation of it requires testing via a pilot study for transferability beyond the study findings and suggestions. This would support ongoing development and refinement of the framework, informing related policy and practice.

The meeting space framework contributes to the debate and discussion around suicide awareness and prevention and offers an alternative starting point for meeting the other. It implicates the student nurse as a coparticipant in an experience. It softens the edges of the desire to rescue and stop suicide through coercion and practical action. It encourages space and being as the vehicle to engage and supports exploration to choose an alternative course of action through an illuminating space.

There is a plethora of qualitative research regarding this area of care. There is a lot to learn from colleagues whose work is engrained with the existentialism of dying and spirituality. This includes joint research and learning with hospice staff for instance, and research into the domain of how we meet people, which would be a positive area to explore with this research. Influencing mental health care from the palliative arena is strongly advocated by Cooper and Cooper (2018).

Considering policy on suicide

Earlier in chapter four, suicide, policy and public safety was discussed, and it was identified that nursing was highlighted in the delivery of suicide prevention through national policy. Anderson and Jenkins (2006) voiced that ‘all nurses are directly influenced by the focus of the national suicide prevention strategy’ (p.648) and Barr et al. (2005) advocated regular up-to-date risk assessment training for frontline clinical staff. Responding to the political rhetoric at that time, Cutcliffe and Stevenson (2008) advocated that policy emphasis should be on connecting the person with humanity as part of a constructive approach to care, as opposed to a focus on risk management strategies that were misaligned with the emerging evidence form literature. It is ten years on and I would echo the observations of Cutcliffe and Stevenson and Gilje et al. (2005). Deep self reflections and existential issues are highlighted as disclosures in their research and suggest that such knowledge is made visible in the nursing literature. This chimes with the research findings here, where meaning making and development of spiritual and existential views of suicide were crucial to affecting genuine care.

The emerging evidence base combined with the voices of those who have been suicidal are powerful and serve as an educational tool, reminding us that, first and foremost, we share humanity, and this is the point of meeting and connection. Nursing is traditionally associated with interhuman aspects of care provision, rightly so; however national policy refers to all professionals and the dominant

discourse is still that of goals and trajectories with little or no focus on educating how to be with ourselves and others and respond to those who are suicidal in a human way.

Politically, it is a fitting time to share *the meeting space framework - crafting conversations about suicide in nurse education*. As aforementioned, the NMC (2018) have now published proficiencies across all fields of nursing to recognise and respond to those who are suicidal. A framework for conversation about suicide could be a timely interjection.

Notable challenges

The combined subject of suicide with spirituality appears nothing more than contentious when returning to the literature. It is evident from literature that these subjects are regurgitated with little noted impact on practice. The issue of suicide was discussed in depth in chapter four. In relation to spirituality, the RCN commissioned an online survey in 2010 regarding spirituality in nursing. Respondents acknowledged the need for spirituality for quality care but collectively concluded they needed further guidance and support from professional and governing bodies. Nurses were reluctant to engage in spiritual care due to the ‘fears, misconceptions and myths’ related to it (RCN, 2010, p.5). An earlier review for the Mental Health Foundation (Cornah, 2006) listed barriers such as lack of time, discomfort with the subject matter, stepping outside comfort zone and lack of interest of engaging in spiritual care. Suicide has made it into the NMC (2018) proficiencies, along with the assessment and review of spiritual needs. Respecting spiritual beliefs is referred to on in the International Council of Nursing Code of Ethics (ICN, 2012) and identified as a component of whole person care. Again, echoing suicide, it seems that there is a disjoint between what is stipulated between governing bodies and what is needed to what is done. The terrain is multifaceted and complex. It must be the individual intention of each nurse to endeavour to meet the other and to allow themselves to be met. Nurses are looking in the wrong places. The answers are not entirely with governing bodies but with the users of services who are actively giving nurses permission to be human, to reach out and connect.

Closing thoughts

This thesis commenced with the sharing of personal and professional experiences of suicide and expanded to discuss historical, biomedical and social aspects of suicide. Latterly suicide was linked as synonymous with seeking meaning and being met as a human, hence spirituality was discussed as an important factor of being with suicidal people. The qualities of being met expand beyond words and into the space we occupy. From this, I conclude that suicide, as applied in general, is an excruciatingly limiting term. It is perpetually applied to people but does not capture the spiritual place of the person. Depending on how one sees affects how the person is met. Those who are suicidal can be subjected to limited responses for a multitude of reasons, as iterated in the research enclosed. It is pertinent to refer to the starting point of the nurse as helper and human being, which is pivotal in creating a certain kind of space for the co-creation of conversations about suicide. Bound up with the nurse is a historical, contextual and symbolic representation aligned with ritual and healing. To be a

nurse means to be in possession of a certain ethic beyond language and consistent with humanness. With that is the position in which nurses adopt to meet the person and how they see the person. The *meeting spaces framework - crafting conversations about suicide* presents just that, a different way of approaching and seeing with the intention of meeting the other (just as the story of the caves of Ajanta outlined the crucial importance of how we see what is presented to us). The ‘human’ illuminating light of the nurse lights up the space amongst the shadows. However, the nurse must take a step into the shadows using their light as guide to move back and forth, making sense of the meaning of life and death for the person they are with and with that for themselves. Crafting *meeting spaces* requires a different discourse and a vitally different starting point as discussed. It starts with self, building an awareness of where we are with the reality of suicide. It is uncomfortable, as there is a changing, moving energy with a view to meet the person in spiritual borderlands. Until nursing embraces this, the spiritual and human need of those requiring a human response will remain in the dark.

Since commencing this research there has been a significant shift in the social construction of suicide. Charities are relentlessly campaigning, gaining momentum and voice, challenging government and requesting change. The criminal standards of proof for reaching a verdict of suicide has remained since the decriminalisation of suicide in 1961. Recently, voices have been heard with a ruling that coroners should use the civil standards ‘on balance of probabilities’ instead to determine suicide. The discussion was adjourned in parliament in September. This has huge implications, not only for coroners and the recording of such verdicts, but also for families. As referred to earlier in this thesis, there is a discourse that suicide is greatly underestimated and reported, and that current governmental targets are based on such projections, therefore what will this ruling bring and how will this impact upon societal response to those who are suicidal?

There is also a murmuring in the realm of language and classification of risk. An NHS Resolution Report, concerned with learning from suicide-related claims (Oates, 2018), emphasises the unhelpful strategy of ‘cut offs’ for suicide risk (high or low risk), acknowledging that risk is objective and requires listening to what the person says, along with family input as well as input from the wider health care team. Although this is not a new concept, continually advancing social constructs may merge into something meaningful. There are requests throughout suicidal prevention literature, social media blogs and tweets to change language from risk plans to safety plans. This is mirrored in the NHS Resolution Report above with a request to return to therapeutic observation and engagement with suicidal people, latterly championed by Cutcliffe and Stevenson (2008a;2008b) over a decade ago.

Social media is also contributing to change. With the push of a button, lives lost are shared and disseminated causing universal ripples. Music and TV carry messages, challenge thinking and endeavour to express pain, confusion and sensitivities regarding the subject of suicide. There is a

plethora of social media campaigns, and a shift to integrate suicide awareness into schools, workplaces, medicine and nursing. Only last year the ONS reported nursing to be a profession statistically at risk of suicide, whilst the media reported the tragic loss of life of a nurse who was being investigated by the NMC. It raises the question of how we care for each other. There is a sea of change and a range of responses to suicide from the silent, despairing, concerned and deliberately goading. Where does the love for life and others begin and end and how does this influence our intentions as nurses, as humans?

Finally, I return to bridges from whence I started to share an example of a grassroots service motivated by experience and love. The founders of Bridge the Gap (a Facebook community) took it upon themselves to adorn bridges in their local area with messages of hope for people who may find themselves there on the edge of life. This year, the Tyne Bridge is also adorned with messages of hope and affirmation akin to a silent person, someone's voice reaching out as a final aspiration to those who find themselves alone, without love. This, so far from the bridges of my youth.

March, 2004 Jaipur, India

At the moment I am feeling like anything is possible. I look around and see so much colour and vibrance. People are kind and so generous in spirit. There is lightness and warmth in their interactions. They talk to you all of the time, ask if you are ok, so many smiles and many cups of chai in the context of such adversity...

...I am no longer concerned with fragility of the human spirit but in awe of the strength of it.

Appendices

Appendix 1 - Ethical Approval



Professor Kathleen McCourt, CBE FRCN
Executive Dean

This matter is being dealt with by:

Professor Jennifer Watling
Associate Dean
Faculty of Health & Life Sciences
Northumberland Building
Newcastle upon Tyne
NE1 8ST

Date 25/01/16

Dear Annessa Rebar

Faculty of Health and Life Sciences Research Ethics Review Panel

Title: ENGAGING WITH THE 'OTHER': CO-CONSTRUCTING A LEARNING APPROACH TO SUICIDE IN UNDERGRADUATE NURSING

Following independent peer review of the above proposal and your effective changes in response to feedback, I am pleased to inform you that University approval has been granted on the basis of this proposal and subject to compliance with the University policies on ethics and consent and any other policies applicable to your individual research. You should also have recent Disclosure & Barring Service (DBS) and occupational health clearance as needed if your research involves working with children and/or vulnerable adults.

The University's Policies and Procedures are available from the following web link:
<https://www.northumbria.ac.uk/research/ethics-and-governance/>

All researchers must also notify this office of the following:

- Commencement of the study;
- Actual completion date of the study;
- Any significant changes to the study design;
- Any incidents which have an adverse effect on participants, researchers or study outcomes;
- Any suspension or abandonment of the study;
- All funding, awards and grants pertaining to this study, whether commercial or non-commercial;
- All publications and/or conference presentations of the findings of the study.

We wish you well in your research endeavours.

Yours sincerely,

Maria-Ines Martinez
Departmental Ethics Coordinator for Staff and PGR students
Member of the Faculty Research Ethics Review Panel

Vice-Chancellor and Chief Executive
Professor Andrew Wathey

Northumbria University is the trading name of the University of Northumbria at Newcastle



Faculty of Health and Life Sciences Department of Public Health and Wellbeing
Northumbria University Coach Lane Campus, Room G215
Benton Newcastle upon Tyne
NE7 7XA

T: 0191 2156234

E: Annessa.Rebair@northumbria.ac.uk

Date

Covering Letter to Participants

Dear Participant

Re: Engaging with the other: co-constructing a learning approach to suicide in undergraduate nursing

Thank you for expressing an interest in the study which is being carried out as part of a Professional Doctoral qualification at the University of Northumbria.

The interest and commitment to this research comes from both a personal and professional place. The subject matter, personal material and any conversations will be treated with respect and dignity.

You will find that there are a number of attachments to this letter in order to support understanding before giving your consent to take part. These are;

1. An information sheet
2. Group schedule
3. Consent form 1
4. Consent form 2

I understand there is a lot of information to digest, please do not hesitate to call or email if you have any further questions and I will respond personally. My details are enclosed above.

If you do wish to go ahead, your time and commitment is of the upmost value and for that I am genuinely grateful. I look forward to hearing from you.

Warmest regards,

Yours sincerely,

Annessa Rebair

Information Sheet

Engaging with the other: co-constructing a learning approach to suicide in undergraduate nursing

Information Sheet – Expert by Experience

You are being invited to take part in this research study. Before you decide it is important for you to read this leaflet, so you understand why the study is being carried out and what it will involve.

Reading this leaflet, discussing it with others or asking any questions you might have will help you decide whether you would like to take part.

What is the purpose of the study?

The Office of National Statistics reported 6223 deaths by suicide in the UK in 2014, a 4% increase on the previous year with the North East accounting for the highest rates in England. Suicide awareness and prevention is therefore a significant public health concern and of importance to those working in the health care arena. Interestingly, at present it is not a requirement for suicide awareness to be included in all areas of nurse training and evidence shows that nurses do not feel they have the skills and knowledge to recognise the signs or start conversations about suicide.

The aim of this study is to produce an educational session on talking about suicide for the preregistration nursing programme. It will also contribute to and develop theory and understanding about what is helpful.

The focus is to understand what is needed by student nurses to support the engagement of conversations about suicide and to learn what was helpful to experts by experience when suicidal. An educational session will be produced by all participants from the data and taught on the preregistration programme to student nurses.

Why have I been invited?

You have been contacted via the organisation Launchpad who as you know are actively involved in ensuring the voice of service users are heard in local mental health services. The investigator is very interested in hearing about your experiences of conversations about suicide with nurses and professionals and wants your voice to be heard through the education of students, ultimately informing clinical practice.

Please submit an expression of interest either via email or you can leave a voicemail for me. I will also attend a Launchpad meeting so you can meet me face to face before deciding to go forward. To participate you must have had an experience of feeling or actively being suicidal at some point in the past and have been in a position whereby you have spoken to health care workers about this.

Do I have to take part in this study?

No. It is up to you whether you would like to take part in the study. I am giving you this information sheet to help you make that decision. If you do decide to take part, remember that you can stop being involved in the study whenever you choose, without telling me why. You are completely free to decide whether or not to take part, or to take part and then leave the study before completion. Deciding not to take part, or leaving the study, will not affect your rights or care.

What will happen if I take part?

You will be contacted by email and telephone and invited to an initial group meeting in order to ask any further questions and to meet the rest of the participants. The process of the research will be discussed further. Details are attached separately to this form. If you are happy to proceed consent will be requested at this meeting.

After signing a consent form, the investigator will agree dates and attendance of the first group meeting confirming the venue. If you do decide to take part the investigator will ask if for the name of a contact person of your choice to be provided just in case you do experience any emotional discomfort and may require extra support.

What are the possible disadvantages of taking part?

Time may be an inconvenience as the research is scheduled to take place over a year and for 7-10 sessions to be attended.

The subject is also very sensitive and therefore it is possible that you may experience some emotional discomfort. It is important to reassure you that great deal of thought has been given to this and there is a lot of support available and a risk assessment has taken place. The investigator is trained and experienced in offering support to people who are distressed. An observer will also be present during sessions, they will offer any support to those during and after the session. A short debrief will also occur at the end of every session. A suitable waiting area will be available with drinks for those wishing to bring a family member or friend along for support.

What are the possible benefits of taking part?

By taking part in the study you will be partaking in group discussions and will help develop new theory in relation to conversations about suicide. You will contribute and coproduce an educational session with student nurses. The resulting product will be taught and evaluated on the preregistration nursing programme. You will be helping to develop informed teaching strategies contributing to positive practice in nursing approaches to care of the suicidal person.

Will my taking part in this study be kept confidential and anonymous?

Yes. Your confidentiality and anonymity is respected and remember you can withdraw at any point by informing the investigator this will not affect your current or future care

Your name will not be written on any of the data we collect; the written information you provide will have an ID number, not your name. Your name will not be written on the recorded interviews, or on the typed up versions of your discussions from the interview, and your name will not appear in any reports or documents resulting from this study. Original recording will be stored as per university policy in locked cabinets, password protected on computers and only the investigator and supervisor will have access to these. The consent form you have signed will be stored separately from your other data.

The data collected from you in this study will be confidential. The only exception to this confidentiality is if the researcher feels that you or others may be harmed if information is not shared.

How will my data be stored and destroyed?

All paper data, including the questionnaires, the typed up transcripts from your interview and your consent forms will be kept in locked storage. All electronic data; including the recordings from your interview, will be stored on the University U drive, which is password protected. All data will be stored and destroyed in accordance with University guidelines and the Data Protection Act (1998).

What will happen to the results of the study?

They will be written up for the presentation of a Professional Doctorate. The general findings might also be reported in a scientific journal or presented at a research conference, however the data will be anonymised and you or the data you have provided will not be personally identifiable, unless we have asked for your specific consent for this beforehand. The findings may also be shared with other organisations/institutions that have been involved with the study. We can provide you with a summary of the findings from the study if you email the researcher at the address listed below with your request.

Who has reviewed this study?

Before this study could begin, permissions were obtained from Northumbria University and Launchpad. Launchpad is an established local organisation by and for mental health service users aimed at ensuring the voice of those using mental health services are heard and represented throughout service provision in Newcastle (see <http://launchpadncl.org.uk/>).

Who has funded this study?

Northumbria University. Funding will be sourced to support travel expenses and parking for the duration of the study.

Contact for further information:

Researcher email: Annessa.Rebair@northumbria.ac.uk **Telephone** 0191 215623

Researcher Supervisor: Toby.Brandon@northumbria.ac.uk

Please note that this information sheet can be made available in audio if required

An information sheet for families, carers and friends is also available

Information Sheet

Engaging with the other: co-constructing a learning approach to suicide in undergraduate nursing

Information Sheet- Student Participant

You are being invited to take part in this research study. Before you decide it is important for you to read this leaflet, so you understand why the study is being carried out and what it will involve.

Reading this leaflet, discussing it with others or asking any questions you might have will help you decide whether you would like to take part.

What is the Purpose of the Study

The Office of National Statistics reported 6223 deaths by suicide in the UK in 2014, a 4% increase on the previous year with the North East accounting for the highest rates in England. Suicide awareness and prevention is therefore a significant public health concern and of importance to those working in the health care arena. Interestingly, at present it is not a requirement for suicide awareness to be included in all areas of nurse training and evidence shows that nurses do not feel they have the skills and knowledge to recognise the signs or start conversations about suicide.

The aim of this study is to produce an educational session on suicide for the preregistration nursing programme, contribute to and develop theory around the subject.

The focus is to understand what is needed by student nurses to support the engagement of conversations about suicide and to learn what was helpful to experts by experience when suicidal. An educational session will be coproduced by all participants from the emergent data and taught on the preregistration programme to all fields of nursing.

Why have I been invited?

You are a student nurse and therefore represent the area of Adult, Mental Health, Child, Midwifery or Learning Disabilities.

All interested parties are asked to submit an expression of interest, please note you will not be excluded by age or gender. Two representatives from each field of nursing will be randomly selected to take part after expressions of interest have been received. You will be contacted by email and telephone and invited to an initial meeting in order to ask any further questions before deciding whether to take part and to give consent.

Do I have to take part?

No. It is up to you whether you would like to take part in the study. I am giving you this information sheet to help you make that decision. If you do decide to take part, remember that you can stop being involved in the study whenever you choose, without telling me why. You are completely free to decide whether or not to take part, or to take part and then leave the study before completion. Deciding not to take part, or leaving the study, will not affect your rights as a student or any ongoing education.

What will happen if I take part?

You will be contacted by email and telephone and invited to an initial group meeting in order to ask any further questions and to meet the rest of the participants. The process of the research will be discussed further. Details are attached separately to this form. If you are happy to proceed your consent will be formally requested at this meeting. After signing a consent form, the investigator will agree dates and attendance of the first group meeting confirming the venue.

By agreeing to take part in the research you will be consenting to your GT being informed of your participation. This is a supportive approach in relation to learning and any pastoral requirements that may emerge as part of the process.

What are the possible disadvantages of taking part?

Time may be an inconvenience as the research is scheduled to take place over several months (see attached schedule).

The subject is also very sensitive and therefore it is possible that you may experience some emotional discomfort. It is important to reassure you that great deal of thought has been given to this and there is a lot of support available and a risk assessment has taken place. The investigator is trained and experienced in offering support to people who are distressed. An observer will also be present during sessions, they will offer any support to those during and after the session. A short debrief will also occur at the end of every session. A suitable waiting area will be available with drinks for those wishing to bring a family member or friend along for support.

What are the possible benefits of taking part?

By taking part in the study you will be partaking in focus groups and group discussions and will help develop new theory in relation to conversations about suicide. The resulting product will be taught and evaluated on the preregistration nursing programme. You will be helping to develop informed teaching strategies contributing to positive practice in nursing approaches to care of the suicidal person.

Will my taking part in this study be kept confidential and anonymous?

Yes. Your confidentiality and anonymity is respected and remember you can withdraw at any point by informing the investigator this will not affect your current or future care or tuition. Your name will not be written on any of the data we collect; the written information you provide will have an ID number, not your name. Your name will not be written on the recorded interviews, or on the typed up versions of your discussions from the interview, and your name will not appear in any reports or documents resulting from this study. Original recording will be stored as per university policy in locked cabinets, password protected on computers and only the investigator and supervisor will have access to these. The consent form you have signed will be stored separately from your other data. The data collected from you in this study will be confidential. The only exception to this confidentiality is if the researcher feels that you or others may be harmed if information is not shared.

How will my data be stored and destroyed?

All paper data, including the questionnaires, the typed up transcripts from your interview and your consent forms will be kept in locked storage. All electronic data; including the recordings from your interview, will be stored on the University U drive, which is password protected. All data will be stored and destroyed in accordance with University guidelines and the Data Protection Act (1998).

What will happen to the results of the study?

They will be written up for the presentation of a Professional Doctorate. The general findings might also be reported in a scientific journal or presented at a research conference, however the data will be anonymised and you or the data you have provided will not be personally identifiable, unless we have asked for your specific consent for this beforehand. The findings may also be shared with other organisations/institutions that have been involved with the study. We can provide you with a summary of the findings from the study if you email the researcher at the address listed below with your request.

Who is Organizing and Funding the Study?

Northumbria University

Funding will be sourced to cover travel expenses and parking during the study.

Who has reviewed this study?

Before this study could begin, permissions were obtained from Northumbria University and Launchpad. Launchpad is a an established local organisation by and for mental health service users aimed at ensuring the voice of those using mental health services are heard and represented throughout service provision in Newcastle (see <http://launchpadncl.org.uk/>).

The Faculty of Health and Life Sciences Research Ethics Committee at Northumbria University have reviewed the study in order to safeguard your interests, and have granted approval to conduct the study.

Contact for further information:

Researcher email: Annessa.Rebair@northumbria.ac.uk

Researcher Supervisor: Toby.Brandon@northumbria.ac.uk

Note that an audio version of this can also be made available if required. A leaflet for family, friends and carers is also available.

Consent Form 1

FOR USE WHEN PHOTOGRAPHS/VIDEOS/TAPE RECORDINGS WILL BE TAKEN

Project title: Engaging with the other: co-constructing a learning approach to suicide in undergraduate nursing

Principal Investigator: Annessa Rebar

I hereby confirm that I give consent for the following recordings to be made:

Recording	Purpose	Consent
voice recordings	To capture an interview and discussion on suicide and gather relevant data. The recording will be typed up and analysed to identify themes and categories. All names mentioned during discussions will be replaced by a pseudonym or code in the typed text.	I consent to my contribution being recorded, typed and analysed for the research

Clause A: I understand that **your supervisor** may be exposed to the **anonymous transcript of the recording(s)** and be asked to provide observations. The outcome of such observations will help with the categorization of data and will be shared as part of the data analysis. My name or other personal information will never be associated with the recordings and transcript.

Tick or initial the box to indicate your consent to Clause A Yes ☐ No ☐

Clause B: I understand that **short excerpts** from the transcript may also be used for teaching and may be presented to students/researchers in an educational/research context. My name or other personal information will never be associated with the transcripts.

Tick or initial the box to indicate your consent to Clause B Yes ☐ No ☐

Clause C: I understand that **short excerpts** of the transcript may be published in an appropriate journal/textbook. My name or other personal information will never be associated with this. I understand that I have the right to withdraw consent at any time prior to publication, once the excerpts are in the public domain there may be no opportunity for the effective withdrawal of consent.

Tick or initial the box to indicate your consent to Clause C Yes ☐ No ☐

Signature of participant..... Date.....

Signature of Parent / Guardian in the case of a minor
..... Date.....

Signature of researcher..... Date.....

Consent Form 2

CONSENT FOR TAKING PART IN A STUDY WHICH MAY CAUSE PSYCHOLOGICAL DISTRESS

Project Title: Engaging with the 'other': co-constructing a learning approach to suicide in undergraduate nursing

Principal Investigator: Annessa Rebar

Please tick or initial where appropriate

I have carefully read and understood the Participant Information Sheet Yes ☐ No ☐

I have had an opportunity to ask questions and discuss this study and I have received satisfactory answers

Yes ☐ No ☐

I understand I am free to withdraw from the study at any time, without having to give a reason for withdrawing, and without prejudice.

Yes ☐ No ☐

I understand that by taking part in this study I may be exposed to situations that may generate some psychological distress that may become apparent during and/or after the study has finished. I accept this.

Yes ☐ No ☐

I agree to take part in this study

Yes ☐ No ☐

Signature of participant.....

Date.....

Signature of Parent / Guardian in the case of a minor

.....

Date.....

Signature of researcher.....

Date.....

Appendix 2 (i) - Example of initial coding

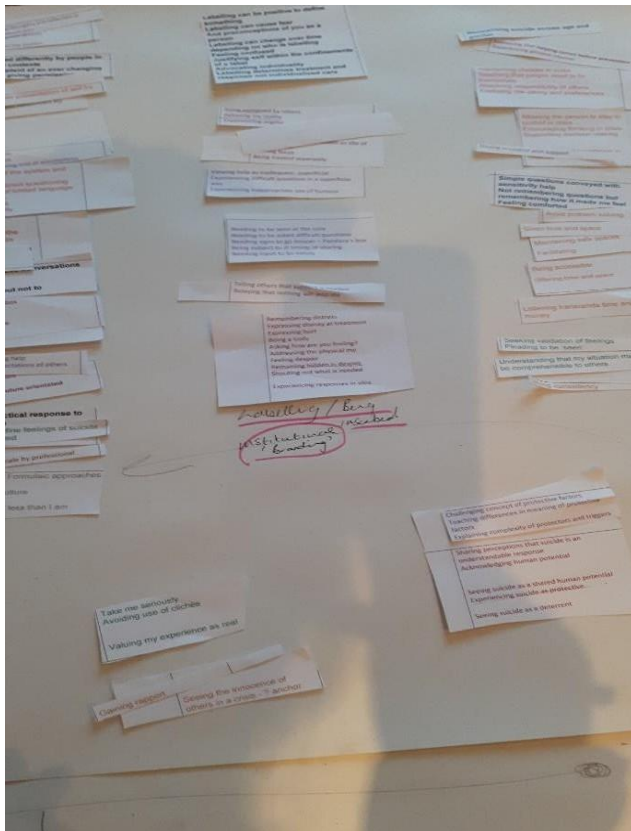
<p>I – (L208-09) You have given some really warming examples of how people have spoken to you. Was there anything else that they were doing to connect or try and connect with you?</p> <p>Lilly (L 210-220) – I think it was always hard because I had had people involve in my care for long periods of time who would try and connect with me but I was like no I am not and they would think that was a stubbornness in me to be fair but I think it took that sort of brutal honesty sometimes because I had a CPN who said to me you have no idea how this affects me I will go home on a Friday night and I worry about you all weekend because I know what kind of place you are in. Some people go oh my god they have said that but I could accept that bit but then I had another nurse who when I was sat in A & E being assessed said, no wonder your husband left you and no wonder you nearly got your children taken away because of the way you behave you have brought this all on yourself. So that kind of honesty which wasn't honesty really that was just her saying that I was a waste of space basically and that was not caring compassion at all but yet I could accept the CPN saying that I am human as well and actually this does affect me and I actually teach that to people now and I tell people that story about the fact that actually nurses are just human and they aren't mind readers and that actually you have to give the information and you have to give them the honesty and the trust as well as them giving it back to you it is a two way process but that took a long time for me to work that out basically.</p> <p>I – (L222) How do you know when you can be honest and trust somebody?</p> <p>Lilly – (L224-230) You know within seconds. You know within seconds of walking through a room, through somebody talking to you or looking at you how they are going to behave with you and I don't know, people would say well that's just you but actually X would tell you the same thing and I think it is something that you learn very quickly within mental health services especially because you see a lot of contempt and a lot of stigma and you know that stigma exists so you don't want to be there and you don't want to be in that position where that could happen but I know when I walk into a ward or if I see staff, I know the ones that are there because they genuinely care and the one that are there just to pick up a pay cheque at the end of the day and I can pick it out immediately.</p> <p>I – (L232) That's interesting. What are you picking out?</p> <p>Lilly– (L234-235) The body language the way that they look at you, the way that they connect with you, their eyes, you can just see, or they don't connect with their eyes. It is more important than the words that they use you know. It is bigger, it's the whole thing.</p>	<p>Being uncommunicative Choosing not to connect Being in control</p> <p>Hearing that I don't matter Hearing that I matter Solidifying my humanity Acknowledging humanity in the others Changing perceptions</p> <p>Sensing Anticipating interactions Assessing others Intuiting Anticipating negative contexts Becoming attuned Becoming institutionally intelligent Genuinely caring</p> <p>'Seeing' authenticity Being, more than word</p>
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Example of focussed coding

Initial code	Focussed Codes	Final sub category
Hearing that I don't matter	Branding	Non-presencing
Acknowledging humanity in the others		
Changing perceptions	Gaining wisdom	Seeing other
Becoming attuned Becoming institutionally intelligent		
Being uncommunicative Choosing not to connect Being in control	Seeking safety	'Walking the navigation line' (in vivo)
Anticipating negative contexts Sensing		
Anticipating interactions Assessing others Intuiting		
'Seeing' authenticity * Being, more than words* Hearing that I matter Genuinely caring Solidifying my humanity	Experiencing authentic care	Presencing

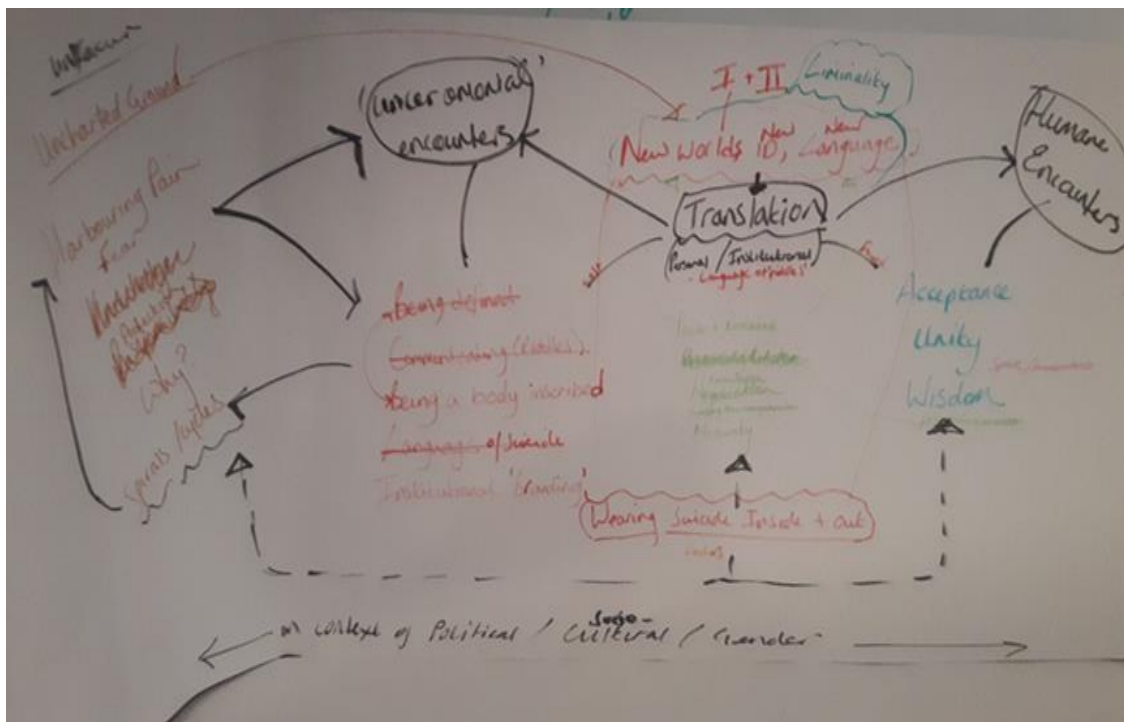
Appendix 2 (ii) - Development of categories

Example; developing focused codes



Focused codes were developed for each participant and through theoretical sampling. Through process of constant comparison and Colour coded interview data corresponding to each participant. Codes were related back to data text as corresponding line numbers as shown above in initial coding were printed on the back of each code.

Example; Mapping concepts and codes, finding prevalence and movement



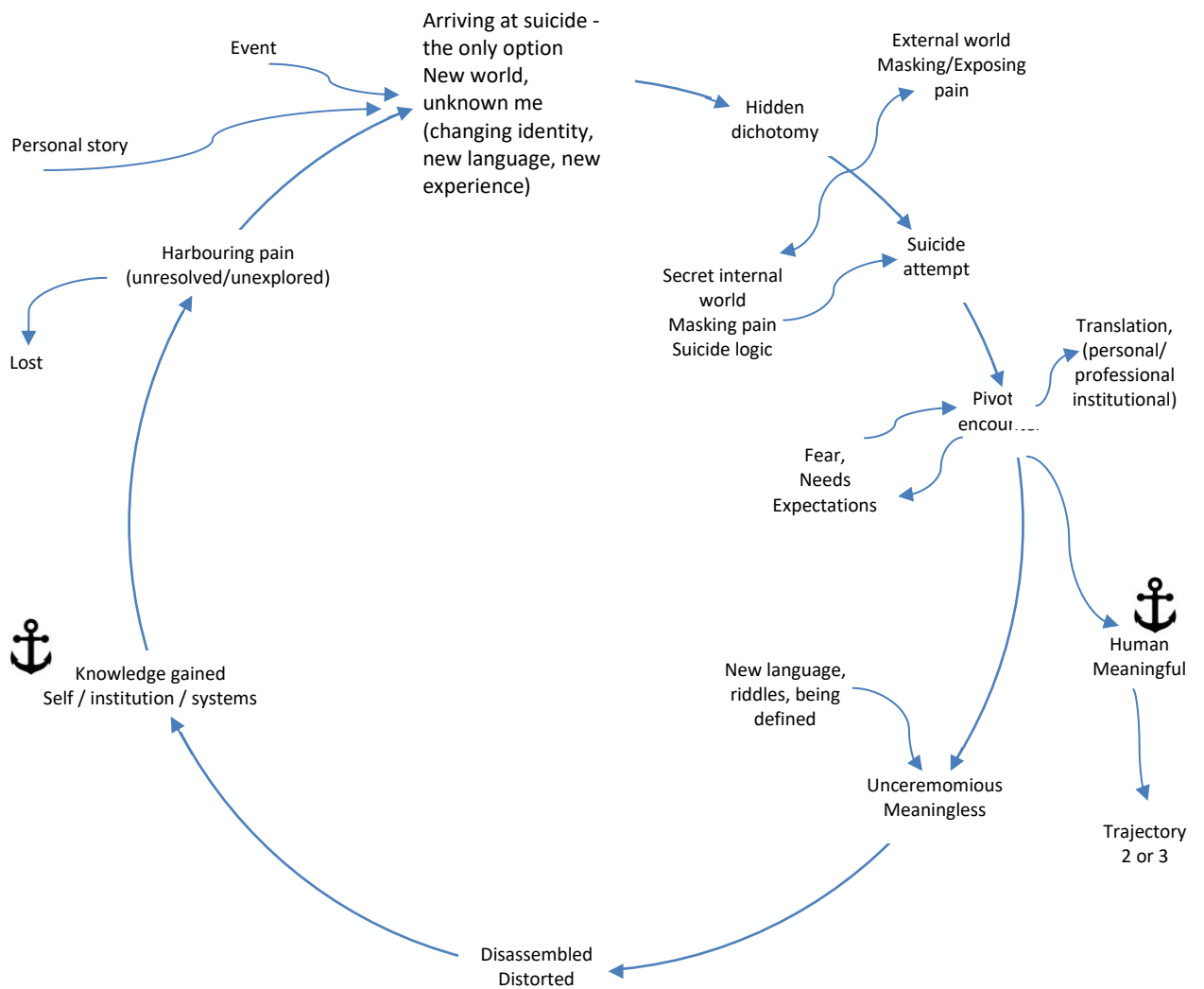
Further Development of Categories

A representation of development of categories as of December 2016. There were a few incarnations, categories collapsed and moved as they became refined. Categories were refined through mapping and constant comparison analytical method allowed for theoretical sensitivity. In depth data analysis, returning to literature, comparison of data with data, code with code, category with category as proposed by Charmaz, (2006). The final core category, categories and sub categories are presented in the findings and discussion chapter.

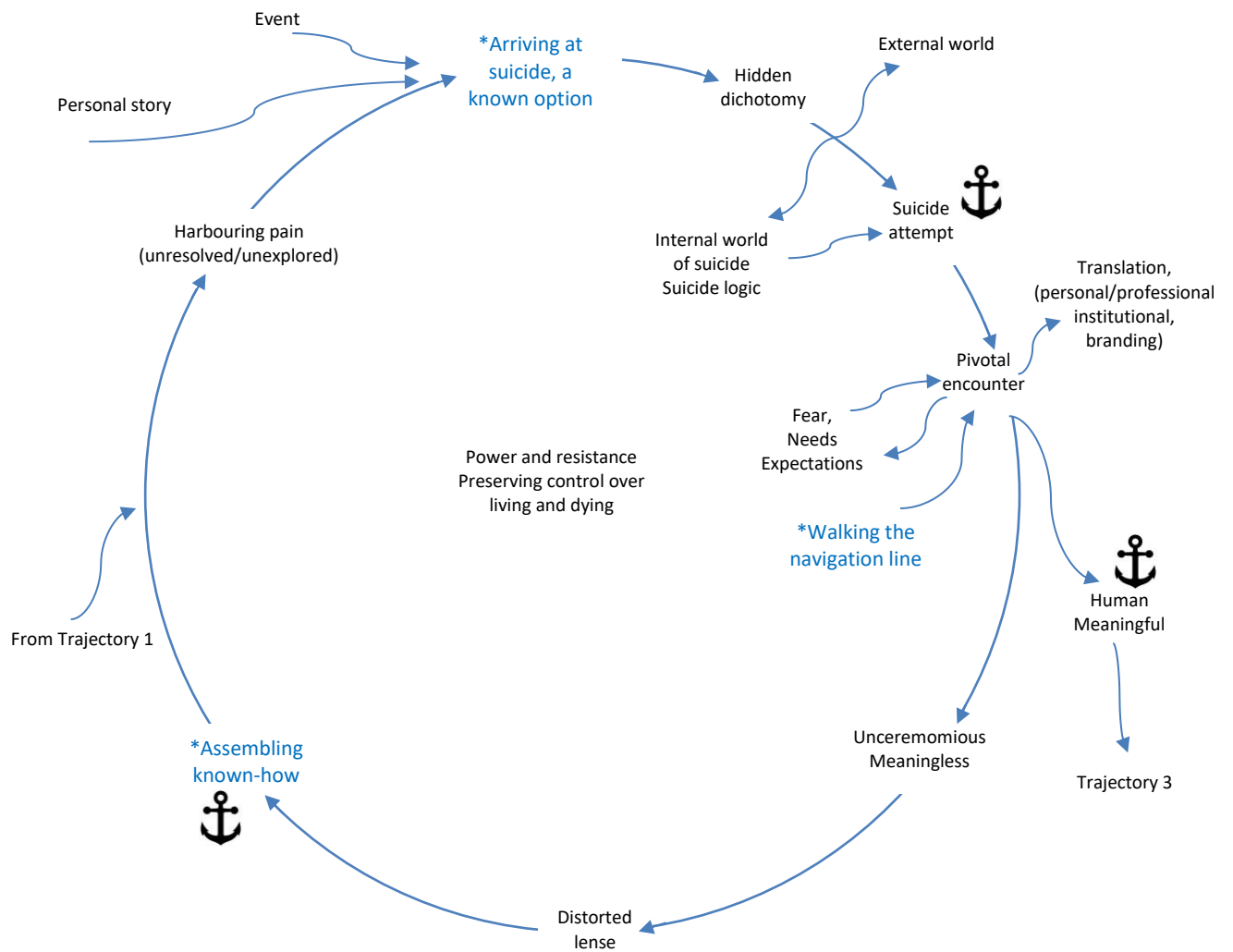
Category	Sub categories			
Naivety	Self?	Others?	World/? systems	
Arriving, Uncharted/Chartered ground	New world, unknown me New world two, new language	Cycling/ spiralling Assembling know how?	Wise teacher	
Presenting a living dichotomy	Internal world	External world	Suicidal logic	
Pivotal Encounter	‘Un-ceremonial’ Meaningless – expectations thwarted		‘Humane’ Meaningful - expectations met ?	
	Distorted lens =	Devalued /misrepresented	Synergy	Authenticity
	Physical focus	Disassembly	Co-presencing	Being human
	Expectations met/ thwarted		‘see me’	
Translation The language of suicide	Personal	Professional – institutional branding	Socio-political	
Fear	Protecting others	Loss	Stigma	
Harbouring pain	Unresolved /unexplored	Why?	Cycle of emotions	
‘walking the navigation line’	Negotiation	Invoking resistance	Moral preservation	
Anchors / Acceptance	Anchors	Unity and wisdom	Redressing personal expectations	
		Why?		

Appendix 2 (iii) - Trajectories 1, 2 and 3

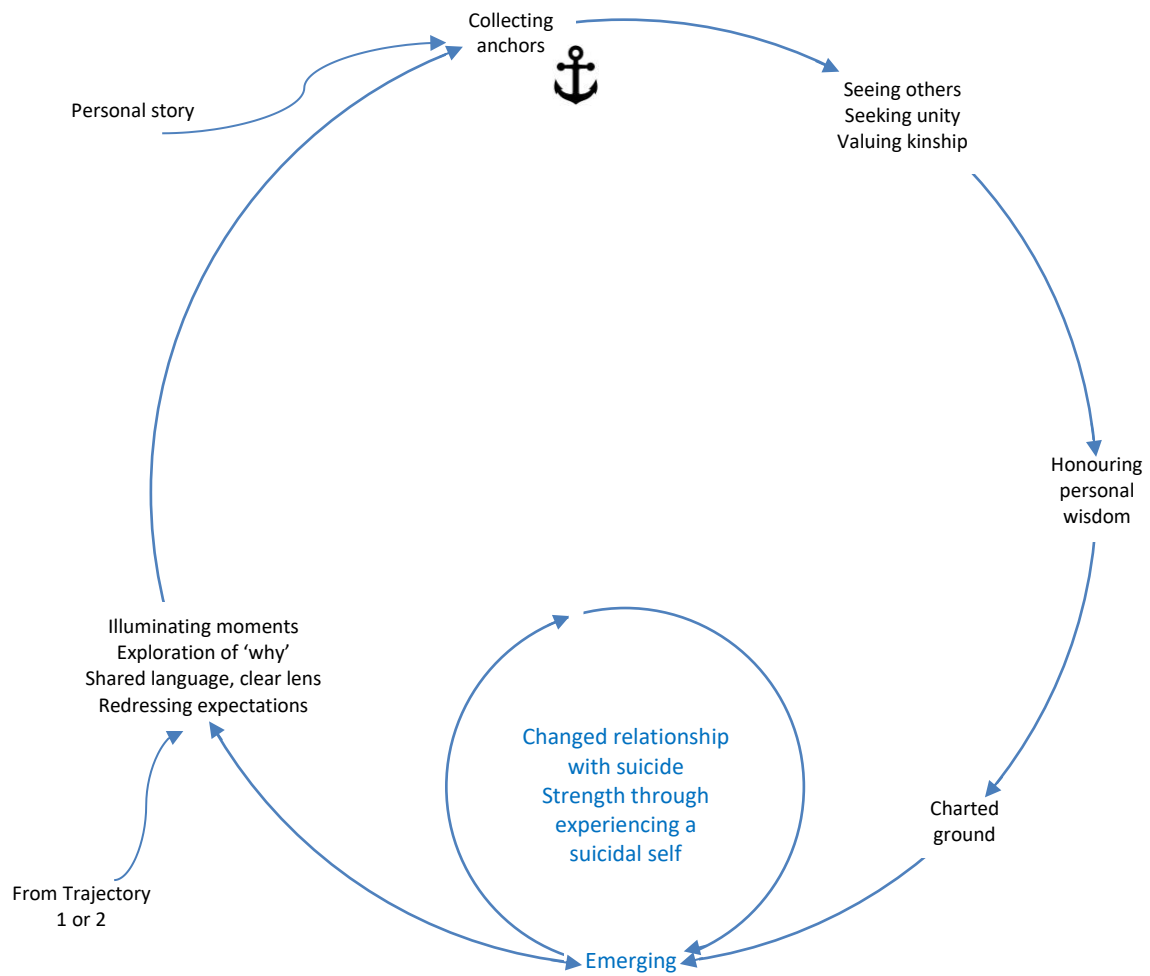
Trajectory 1 – Arriving in Uncharted Space



Trajectory 2 – Cycling - Distorted Space

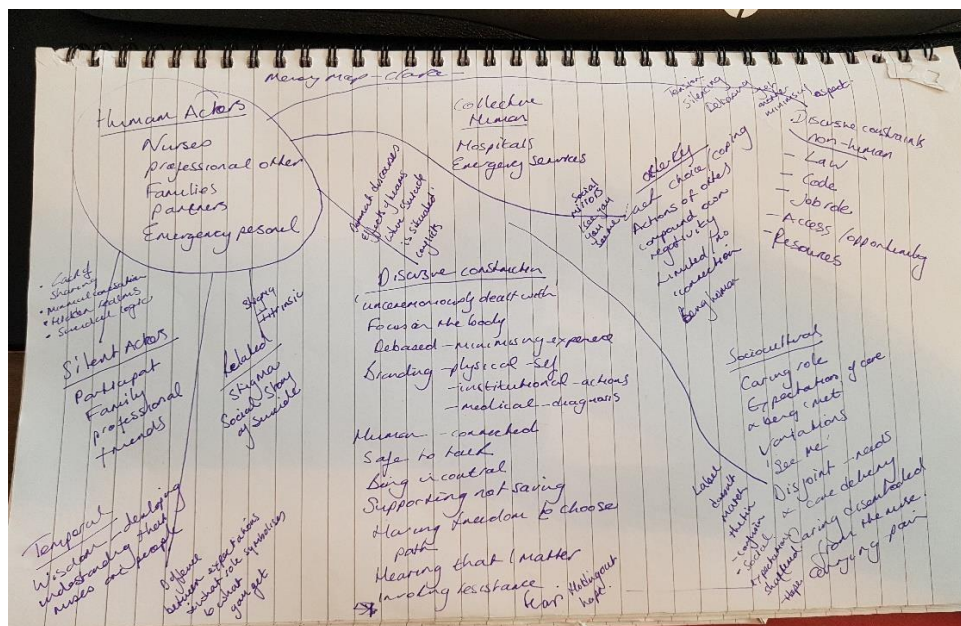


Trajectory 3 – Emerging – Illuminating space



Appendix 2 (iv) - Conceptual mapping to develop theoretical abstraction

Messy map technique (Clarke, 2005)



Theoretical notes following messy map activity (4.2.17);

Human actors - Sociocultural
- that construction of what is/ helpful
the symbolize. That's experience.
holding out hope. By the very need that
they want to talk, they all want
to be asked why & to tell their story
Perhaps this is key - the agent &
disempowered that the hope
is shattered, expectations thwarted
hope - (not considered to be hope)
is lost - rise as hope giver
This is the symbolization
It is an attempt to experience anything
other than care in helplessness within
the context of being suicidal.
Re-animating ideas of self.
Fear of being recognized.
Further impact of meaningless
encounter with another - the "other"
(Involving resistance - to maintain
freedom is an unquenchable fight
to maintain space as choice &
protective or the notion of freedom in
a restricted world.
Space to be
- Express myself
- to be human
Includes in discourse

Human Actors & Discourse
The human & disempowered bodies.
Meaning the whole person / whole experience & focusing
on the tangible aspect of the body.
Suicide is situated within medical
socio-political - religious domain - contentious
where does it sit outside of that?
What is the human domain? Essentially
the human domain is all of that as we are
affected by all of those discourses -
*What discourse essentially deals with
helplessness?
*Beyond discourse of
if suicide is a response to the problems of living
(Barter) & sketches through many discourses -
how can it be addressed? That's what touches
what needs to be the soul of living.
Essentialism
*Symbolism? = *
Essentially suicide sits with helplessness
& the need to experience
from within.
The nurse symbolizes that
when expectations are thwarted.
I imagine a disorientation.
Suicide - a way to
is essentially the wrong word -
connotations wrong
Need to ascertain what suicide means
for the person - suicide is one

Appendix 2 (v) - Examples of reflexivity and memo's

Reflexive memo

1st interview – Shaun (22nd February 2016)

I am anticipating how the interview will go today. My background and 20 years experience of working with people in the context of mental health services would be helpful. I am acutely aware that I am coming to this with a different hat on so to speak, but, inherently, we are all of our experiences. What would a good interview conversation look like in the context of research? I do not know how else to be other than curious about what is shared. The interview is semistructured so there is room for departure depending upon what emerges. This is the first interview, so a point of departure. I must be mindful of asking leading questions whilst following the line of enquiry. There is some nervous anticipation. I am not sure why or what this is about. Perhaps it represents the enormity of the task ahead and the acknowledgement that I am to engage with suicide, in a different way, a matter that walks silently with us as a family. There are reasons, I believe as to why we choose these subjects. Somewhere, stories become bound and evolve, this is healthy, I am curious to know what makes the world even the tiniest bit more manageable at the point of suicidal distress, however this is manifested for the individual. I am wondering how it will be to be immersed in this subject, I expect it will be overwhelming at times.

Post interview notes- I feel elated, what a wonderful conversation. Shaun relayed that he had a positive experience, easy to talk to me and felt connected. He is contactable should I need to return to check out emerging areas of interest. My immediate sense is a struggle to tell a story of pain, this is harboured and manifested in various ways, impacting upon relationships and subsequently on the expectations of relationships. There is something about the many faces a person has during this. The area that stood out was when he was talked down from the Tyne Bridge, there was something powerful and significant about this interaction compared to others. Shaun's memory was one of fondness and gratitude, he felt respected, there was time, treated as a human.

Coding – Interview 1 – Shaun - Extract from notes

There are recurring codes throughout that require further exploration. Needing to tell a story is prominent, juxtaposed by the inability to do so, fear is recurring. Shaun was open and able to see that his fear was linked to stigma and fear of what would happen if he shared. He worried that it would affect his family. As a result, in his suffering, Shaun took on the role as protector, shielding the family from his experiences, others did not see or understand this, hence his presentation was not understood. There is also a theme of testing out the situation to see how much can be shared in professional contexts too, for safety purposes. This must be an incredibly difficult barrier to break

through, there's a lot to be said about the power of the encounter. There is something unique, something powerful about what encourages sharing and what does not. The research question is, what is needed by the suicidal person to engage in meaningful conversations about suicide? I am also getting what is not helpful as part of the story. This is a helpful comparison. Shaun felt valued and validated as a human being when he was talked down from the Tyne bridge. There are many qualities cited regarding what was unhelpful and what was helpful in this significant encounter, I need to follow this line and understand if this is featured in the next interview.....I have some direction now and can evolve the interview. By the nature of the inclusion criteria, an interaction has taken place at the point of suicidal thoughts, whether this was helpful or not is a point of inquiry, and whether an actual conversation about suicide took place is also another matter of inquiry given the checking out process and perceived barriers. It appears at this juncture that being suicidal and having a conversation about suicide did not always happen. It was not explicit. I need to check this out in the next interview too. Referring to SI and SC, it would be useful to understand what the expectations are from the persons perspective (the image they hold of the nurse, consequent expectations and experiences and if these are synonymous, and what does it mean if not)? I will explore this area in the next interview. I am wondering if a significant encounter is a feature for all.

MEMO - Member checking and follow up participants, June 10th 2016

Recovery College (Attendees; participants x 4) Start 10.30 – 11.45 Plan

Honesty with where I am, fluid, evolving process, not sure where

taking me, invited to walk with me as I am unsure of what end will look like, flexibility, nature of research

Touching base/ checking

To feel included and updated

Check out story so far, feedback

In the right place? Check my language.

Notes/ see flip chart also

Talked through consistent themes. Note* intent* is a sticking point, need to continue to check this, pertinent in student interviews too, intent is seen as irrelevant to the person, depth of cuts is irrelevant, and method is irrelevant. It is what it is at the point of an attempt. Shaun - 'Do not judge the depth of my pain from the depth of my wounds'. All agree.

Long discussion, similar points, risk, checklist, dehumanising. **Wanting human kindness, response, personable, care.**

'I want to talk about pain, you want to talk about risk.' So, suicide is pain and something

inarticulable for the person, suicide is risk for the nurse/ professional! Completely different focus

Continuums and measure – subjective, not a true measure, person must measure

Offered copies of coding, asked to look over and comment on any words. Gave out post it notes in case people could not ask directly. Group naturally went into outstanding feature and what they thought would be helpful, role play (we are not there yet and may not be!)

Strong feeling towards the use of the word intent and risk. This is interesting as embedded in student language when talking about suicide, strong response, not a shared understanding, it is considered disrespectful, 'I have tried' instead.

This does not encourage engagement. Half story shared, not telling everything. Ideas of professionalism, what does it mean? See Jackson/ Barkers stuff. Adopting language of medicine, fits with what I already understand, depart from nursing language. Very clear message – I want you to be human' being human emanates outwards. But from the person's perspective, there appears to be a whole lot of noise going on distorting what is happening for them. Relook at subcategory, and codes, consolidate, recheck. Year 3 students needed to check prevalence of this?

Reflexive diary entry, December 2017

Year 2 progression meeting

They want to see more of me in my writing. I can be creative apparently! I felt a huge relief when given this 'permission'. My struggle has been with trying to fit a fluid and metaphysical concept into the constraints of how I understand a thesis to be. How symbolic. Why have I been with-holding this? Am I giving enough snippets of my story alongside the account of the research participants? I don't want to over do it, it needs to be balanced, intertwining cultural past and evolving stories, perhaps the reflections and dairy exerpts are the equivilant to the looking glass? I just havn't shared them. I said that I thought it was about spirituality, they agreed; 'where there is shadow there is light,' was said. I believe the shadow isn't outwith but between, it is not an external entity but something that moves between us, and equally shares space with the light.

4th February 2018

Memo – Great conversation with David tonight about his photography. He shared his interest in exploring borderlines and borderlands and what this meant to him. There was a light bulb moment, the concept of borderlines and borderlands reinforced the struggle I have had about not being able to quite pin something down. I am constantly moving through and not connecting with a theroy regarding meeting spaces, I know it's spiritual, the core of meaning. I am thinking of actual Borderlands, England and Scotland and the Border(s) land, and the flow across this space. The space where patriotic identity may be in question. The point is that this is the point! Things are always moving, ebbing and flowing, nothing is fixed. Of course, social constructivist theory supports the

coconstruction of meaning and understanding, I know this. I keep moving back to spirituality, Buber - the meeting place, I – thou, the space in between. It just had not quite aligned. Borderlands and between is where the meeting is required, the place of cross over, nurse, person, human. Uncharted ground – the borderlands of self. Buber fits, we are aligned, I must go back to Buber and review these thoughts with the findings again.

19th February 2018

Travelling account, June 2000, at the beginning of the journey, I was concerned about the fragility of the human spirit, at the end and on return, I was moved by the strength of the human spirit, where is this captured? I also see this reflected in the stories I am hearing.

A memory is emerging; I am 16 and volunteering at a local hospice, it's Sunday morning and I am meeting my best friend Lisa, we are waiting for the metro at Byker. Today is bright and we still wear light jackets, it must be summer. It's 1990. The station is deathly quiet despite our chatter and we are up before most, our shift starts at 7.30am.

I'm reminded of the people I met when I worked there, the nurses were inspiring, they were quiet heroes diligently going about care in the background. They were hardly noticeable in their continuous presence. We gave out breakfast, morning beverages and if short staffed, I would stay to give out lunches. I recall stories and people. I can see them now, I was invited to ask questions, to spend time. I joined one lady, shawled and sitting in her rocking chair; I commented upon a wartime photograph of a handsome officer keeping watch at her bedside. The lady replied that it was her wonderful husband. She recounted courtship, children and life, she smiled warmly, and told me she was ready to see him again. I enquired some more, amazed by her calmness and acceptance of her end of life, she relayed that all was done and there was no need to be afraid.

I recall a strikingly beautiful lady in a green nightdress who tapped her bed and asked me to come and sit with her, to hold her hand. We didn't talk, there was no need. We sat in silence until she said that she would really like some lemon sorbet. And so it was my mission, it felt important, I had never heard anyone ask for sorbet with such intensity. I returned from the kitchen, apologising for the lack of lemon in stock bringing lime instead, it wasn't a problem. I remember how it looked like the most wonderful thing she had ever tasted, she ate slowly with deliberation and rested peacefully, still holding my hand, a contented smile. She oozed the most wonderful energy.

I also remember a young man who welcomed me with a smile and exclaimed he was pleased it was Sunday because I was on shift and apparently I made the best soft-boiled eggs (they had to be a little runny, boiled for just short of 3 minutes). We had a quippy conversation about eggs and how they should be, it evoked a playful rumble with staff who disagreed in their preferences, cooking time differing by 30 seconds at a time. How very personal, the softness of an egg, it still makes me smile. We chatted about the NME and the latest music. He was a heavy metal fan; The Cure paved some common ground between us. I remember returning to duty the following week, NME in hand only

to find someone else in his room.

I learned so much there and remember this time with great fondness. I learned about being careful with words, tone, energy and movement. I learned how the human spirit could find pleasure in the smallest of things and how important the small things were. I was humbled by the ability of people to let go, to find peace, and I was moved by those who struggled and voiced their unreadiness and fear of closing their eyes.

Why has this come to me now and what does it mean in relation to my attempt at synthesising all of this? Being in a space differently? Feeling how profound and energetically extended experiences are? Or just the awakening of a memory that ties all that I am trying to understand; being, living, and dying?

Appendix 3

Related activities regarding suicide in nurse education, policy and practice

Date	Activity
October 2018 – going forward	<p>Invited to NSPAG to present research findings (date tbc)</p> <p>Invited to present research findings stakeholders at NSPA (11.12.18)</p> <p>Invited to Avon & Wiltshire Partnerships Trust Annual Conference to present research findings (date tbc)</p> <p>Share research finding with Launchpad (date tbc)</p> <p>Invited to contribute to expert reference panel by the Centre for Mental Health on suicide in primary care</p> <p>Trustee PAPYRUS national charity (prevention of young suicide) Oral poster presentation – NET conference 2018, Cambridge Professional lead suicide awareness, RCN (Sept 2014- July 2018) Activities included;</p> <p>NSPAG – Attendance to quarterly Government advisory group</p>
2013-present	<p>RCN lead Contribution to Suicide prevention. Contribution to Health Select Committee review and 3rd annual review</p> <p>Influencing Government and agenda to influence NMC re inclusion of suicide across all fields of nursing</p>
September 2018	<p>NMC activity (see emails)</p>
September 2014-October 2018	<p>Elected to NSPA board as lead for RCN in suicide awareness and prevention.</p> <p>Activities include; National suicide awareness day, contribution to national activity and annual conference</p> <p>Invited to contribute to expert reference group for suicide in primary care – The Centre for Mental Health</p> <p>Invited to design RCNi activity Suicide response flow chart for database (Identifying and responding to suicidal person and knowing when to escalate to acute mental health services).</p> <p>Invited by Samaritans to partake in expert reference group for suicide and online activity</p> <p>Article and book chapter publication:</p> <p>Rebair, A., and Hullat, I. (2016). Identifying nurses needs in relation to suicide awareness and prevention. <i>Nursing Standard</i>, 31(27) 44-51.</p> <p>Rebair, A (2018) Suicide awareness and prevention in: Cooper. D.B., and Cooper. J. (Eds) <i>Palliative care with mental health nursing: Ethical Practice</i> pp.267-277</p>

Contribution to National Activity, Nurse Education and Policy

38 Preventing suicide in England: Third progress report

The National Suicide Prevention Strategy Advisory Group

Role

143. This group provides leadership and support in ensuring successful implementation of Preventing suicide in England by advising the Department of Health, and other key delivery organisations and partners, on the relevance of emerging issues for the suicide prevention strategy and discussing potential changes to priorities and areas for action.

Members

Prof Louis Appleby CBE, University of Manchester (Chair)

Mark Smith,	British Transport Police
Louise Robinson	Bereaved By Suicide
James Parker	Chief Coroner's Office
Debbie Large	Coroner's Officers and Staff Association
Nadia Persaud	Coroners Society
Andrew Herd	Department of Health
Ellie Isaacs	Department of Health (Secretariat)
Neil Ralph	Health Education England
Shirley Smith	If U Care Share
Kish Hyde	Independent Advisory Panel on Deaths in Custody
Prof Rachel Jenkins	Institute of Psychiatry
Clare Milford Haven	James Wentworth-Stanley Memorial Fund
Hamish Elvidge	Matthew Elvidge Trust
Tim Kendall	Mental Health Intelligence Network (National
Clinical Lead)	
Daniel Cornelius	Metropolitan Police
Rosie Rand	National Offender Management Service
Simon Medcalf	NHS England
Frances Healey	NHS England
Claudia Wells	Office of National Statistics
Geraldine Strathdee	Oxleas NHS Foundation Trust
Ged Flynn	Papyrus
Gregor Henderson	Public Health England
Helen Garnham	Public Health England
Liz England	Royal College of GPs
Annessa Rebair	Royal College of Nursing
Prof Simon Wessely,	Royal College of Psychiatrists
Ruth Sutherland,	Samaritans/National Suicide Prevention Alliance
Prof Keith Hawton,	University of Oxford
Prof Nav Kapur,	University of Manchester
Prof David Gunnell,	University of Bristol

Contribution to National Activity, Nurse Education and Practice – NMC Standards

I

Thu 05/04, 18:41

Dear [REDACTED]

I have been informed that the NMC have reintroduced suicide and self-harm into the standards of proficiency. I would like to first say a personal thank you for your response to my original email below and taking it forward. I would also like to extend thanks on behalf of the thousands of nurse's who asked for this and for friends and families of loved ones who have lost to suicide. I regularly hear their stories and requests that we should all be able to ask about suicide and respond with compassion.

Kindest regards, Annessa

Annessa Rebair MSc, PG Cert Ed, BSc (Hons) RN Mental Health

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E: Annessa.Rebair@northumbria.ac.uk

Room G215, Coach Lane Campus East, Northumbria University, Newcastle upon Tyne, NE7 7XA, United Kingdom

From: [REDACTED]@nmc-uk.org]

Sent: 27 March 2018 09:35

To: Annessa Rebair <annessa.rebair@northumbria.ac.uk>

Subject: RE: Proficiencies - post consultation - in respect of Council meeting Wednesday 28th [Dear Anessa](#),

Thank you for your email.

In general, the way that the standards have been written is to adopt the approach of being very specific about the skills and knowledge that people will need, to deal with the range of different problems that they will see in practice throughout their career. As you say in your note, we have quite a few references to the skills needed to deal with different types of vulnerability and people at risk all the way through the document. The point of recognising signs of vulnerability in themselves or their colleagues is also made in 1.5 (platform 1).

I will discuss with colleagues where specific mention to Self-Harm or Suicide can be reintroduced. The document as a whole will go to Council tomorrow, but we will be making further amendments before launch which will hopefully be in May

Best wishes and thank you for your comments

From: Annessa Rebar [mailto:annessa.rebar@northumbria.ac.uk]

Sent: 26 March 2018 10:41

To: [REDACTED] <[\[REDACTED\]@nmc-uk.org](mailto:[REDACTED]@nmc-uk.org)>

Subject: Proficiencies - post consultation - in respect of Council meeting Wednesday 28th

Importance: High

Dear [REDACTED]

I am writing as the lead for suicide awareness and prevention for the Royal College of Nursing, I feel moved to address this subject in relation to the proficiencies for preregistration nursing. I was relieved and reassured to see that the NMC included suicide and self-harm as proficiencies for all nurses in the draft documents published last year, it is therefore with great disappointment that I note this has been omitted in the revised standards post consultation.

Since the RCN passed a motion in 2014 to include suicide prevention across all fields of nursing, there has been unwavering support from national groups including the National Suicide Prevention Advisory Group, chaired by Louis Appleby and the National Suicide Prevention Alliance. In addition, the parliamentary review on suicide prevention last year highlighted the need for professionals to be educated in suicide awareness and prevention. Current national policy drivers also require and highlight the need for nurses across all fields to be suitably educated in this area (Public Health Workforce Development strategy, National Suicide Prevention Framework, zero suicide initiative launched at the annual National Suicide Prevention Alliance conference last month, Draft NICE guidelines (Preventing Suicide in Community and Custodial Settings) refer to the need for suicide awareness and prevention in preregistration nurse training) and GMC guidelines now include suicide prevention for trainee doctors. The growing evidence base also demonstrates the need for nurses to be educated in suicide prevention. In light of this, it appears evident that to omit suicide from nurse education would be misaligned with the national drivers and commitment to reducing suicide.

On appraisal of the revised document, I appreciate there is reference to vulnerable people and those at risk, there is also reference to emotional distress and the expression of this though it is specifically referred to as an expression of challenging behaviour and aggression. It may be pertinent to explicitly refer to suicide in this domain (page 73, Part1, 1.1.5) as unless specifically referred to, suicide will not automatically appear on the agenda, it is a difficult subject that we know nurses avoid and desperately request support to address.

I would welcome your thoughts regarding this important area, Thank you in anticipation,

Yours sincerely Annessa Rebar

Annessa Rebar

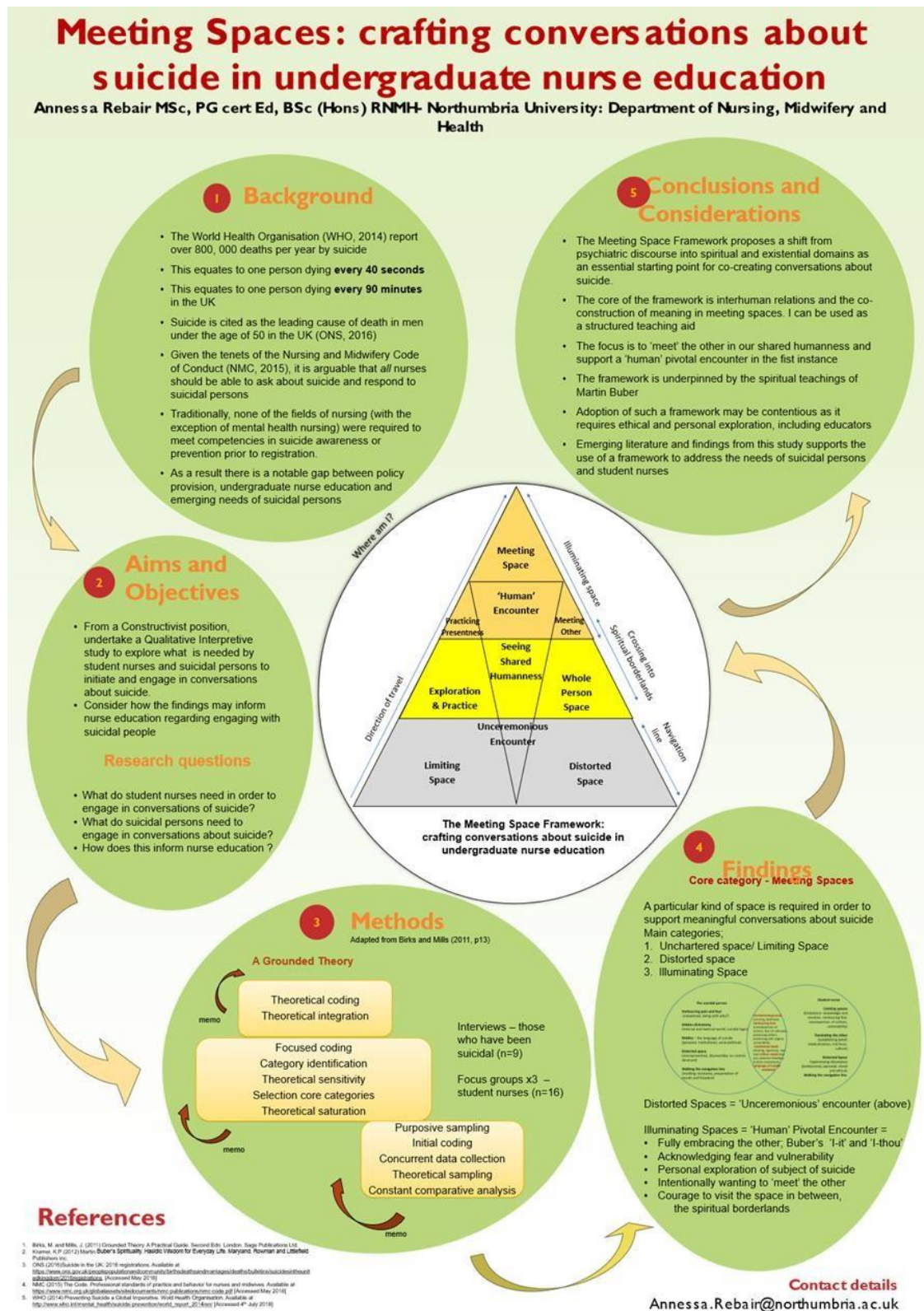
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